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DRUG TREATMENT IN PRISONS

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

MAY 14, 1991

Printed for the use of the
Select Committee on Narcotics Abuse and Control

SCNAC-102-1-4

U.S. GOVERNMENT PRINTING OFFICE

45-887 WASHINGTON : 1991

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-035442-0

H961-29

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DRUG TREATMENT IN PRISONS

TUESDAY, MAY 14, 1991

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON NARCOTICS
ABUSE AND CONTROL,
Washington, DC.

The select committee met, pursuant to call, at 2 p.m., in room 2359, Rayburn House Office Building, Hon. Charles B. Rangel (chairman of the select committee) presiding.

Members present: Representatives Charles B. Rangel, Frank J. Guarini, Solomon P. Ortiz, Edolphus Towns, Nita M. Lowey, Robert E. Andrews, Lawrence Coughlin, Benjamin A. Gilman, Michael G. Oxley, Tom Lewis, James M. Inhofe, Wally Herger, Christopher Shays, William F. Clinger, Jr., Howard Coble, and Jim Ramstad.

Staff present: Edward H. Jurith, staff director; William S. Smith, minority staff director; James Alexander, press officer; Richard Baum, professional staff; Jennifer Ann Brophy, professional staff; Rebecca Hedlund, professional staff; Christina Stavros, administrative assistant; Mary Frances Valentino, minority staff assistant; Melanie T. Young, minority professional staff; David Goodfriend, staff assistant; and Linda Bloss, minority staff assistant.

OPENING STATEMENT OF HON. CHARLES B. RANGEL, CHAIRMAN

Mr. RANGEL. The Select Narcotics Committee hearing will come to order on a very important issue that many of us feel we have not focused enough national attention on.

The United States has unfortunately become a country where we have more people incarcerated per capita than any nation in the world. I was reading today where someone was saying that it is cheaper to go to Harvard than it is to go to prison.

There is no question in my mind that, while it is absolutely necessary that those people who break the law know that they face punishment, I think if we look at our local and State jails that we know that this incarceration system, especially as relates to drug addicts who are doing a crime, is not working. I think the recidivism rate clearly shows that most of our youngsters, upon being discharged, are returning to prison.

The amount of money that local and State governments are spending on prison construction is just absolutely unbelievable, surpassing spending on school construction. And certainly the amounts that are necessary to maintain a person in prison far exceeds that that it takes to maintain a person in school, even an institution of higher learning. In the so-called war against drugs, a lot of national attention is given to the Federal solution as though

it has any impact at all on the problems we face in our cities and States.

I have said, and it hasn't been contradicted, that the total number of drug enforcement agents in the United States and serving in 44 countries is 2,800. Apparently you need real bad luck to get busted by a DEA agent. The small amount of people that are in the Federal prisons, as opposed to the millions that are under local and State supervision, would lead one to believe that the Federal Government is not even making a dent in terms of deterrence.

Now comes the question: What happens after you put them in jail? One would have us believe that our inmates have access to a lot of drugs. But even if we didn't believe that, it seems to me that the inmate doesn't come out any better prepared to cope with the problems of life than he or she was when they went in. Indeed, the common belief is that they come out worse than when they went in.

Now I know that in order for us to get reelected we have got to talk death penalty and longer sentences and more jails. I think it is very sad that a country takes pride in that, as opposed to how many institutions of learning that we have expanded or how many more people will be covered by health care.

But be that as it may, the President of the United States, at the height of his popularity with an outstanding victory in the Persian Gulf, addressed a joint session of Congress and said, "Let's get on now and deal with the domestic issues at hand." And I was sitting on the edge of my seat ready to join with this ever popular President, and the two challenges he made to the Congress were a transportation bill and a crime bill. Maybe this will go down as one of the profiles in courage.

I, for one, think that we can come up with something better. And I hope that this panel of distinguished experts would assist this committee in going to the committees of legislative jurisdiction to shatter the myth that political rhetoric, more jails, longer sentences and the death penalty have a substantial impact on the problems we face in drug addiction today.

I would like to call on my friend and vice chairman of the committee, Mr. Coughlin.

OPENING STATEMENT OF HON. LAWRENCE COUGHLIN

Mr. COUGHLIN. Thank you, Mr. Chairman. I do have an opening statement that I ask to be included in the record.

Mr. Chairman, I would only state that I suspect if you would ask the American public today what they are concerned about, they would say they are concerned about crime, they are concerned about transportation. In addition, the President has presented an education package that is very significant. And I suspect that he is reflecting the views of the American people accurately.

Certainly these hearings are important because the number of offenders entering the criminal justice system testing positive for drugs is simply overwhelming, in a very real sense. I think that we have to look at this issue very carefully. We are anxious to hear your testimony on it, because although it is important to treat offenders in the criminal justice system, we also have needs for treat-

ing others who are not in the criminal justice system. And if treatment within the criminal justice system is not going to be effective, we have a real question of how to allocate our funds.

The President has proposed and the Congress has yet to enact legislation that would require accountability in our treatment programs. And certainly we also need to provide for testing in the criminal justice system in ways that we don't do now.

We are also anxious to hear your testimony because I think that there really is a lack of research and a lack of information as to what can or should be done in the criminal justice system in terms of drug treatment, what can be effective and whether you can force people into treatment or whether that just doesn't work. Certainly in a criminal justice atmosphere, you have an ability to require treatment, but that may not be a desirable thing to do. It may not be an efficient thing to do with our funds.

We look forward to the testimony, and Mr. Chairman, I appreciate your holding these hearings.

[The prepared statement of Mr. Coughlin appears on p. 46.]

Mr. RANGEL. Thank you. These hearings are being held at the suggestion and encouragement of Congressman Frank Guarini from New Jersey, a ranking member of the committee, and also with the support of Congressman Charles Schumer of New York, who is the chairman of the Subcommittee on Crime and Criminal Justice. Our staffs are working very closely together.

The chair recognizes Mr. Guarini.

OPENING STATEMENT OF HON. FRANK J. GUARINI

Mr. GUARINI. Thank you very much, Mr. Chairman. I thank you for holding these timely hearings on drugs and prisons, and particularly in regard to a bill that I introduced, H.R. 730, with you, Mr. Rangel, and the 13 members of this committee, the Judiciary Committee and the Energy and Commerce Committee.

It is very interesting that you have pointed out that it costs for incarceration of juveniles in America $30,000 a year. And, of course, for an adult it goes up to $55,000 a year. And tuition at Harvard comes to just a little over $18,000. So we can see that where we are putting our money is not where it is most productive.

I understand for every dollar spent in prisons to treat people that it is statistically shown that there is a $12 return. So that 12-to-1 ratio is a very impressive figure.

We know that there is a disproportionate number of crimes committed by known drug users. Fifteen times as many robberies and violent crimes are committed by people who are addicted to heroin and cocaine. That is an enormous number. And where people have received treatment, 3 out of 4 people have returned to their social life and to the community and been productive or acceptable in their community; conversely, people who are imprisoned without receiving any treatment whatsoever are 9 or 10 times more likely to return to prison as recidivists. Most will be back within a 3-year term.

So we can see that there are enormous advantages in having drug treatment in prisons. And, of course, we have a State and local panel and we have a Federal panel. We know that we also

have some people that have done some very good work in the nonprofit area. And we benefit from all of what we can learn from the local, State and Federal experiences. Additionally, I understand there is a great deal of treatment given in European prisons which indeed makes a great deal of sense to us.

So I look very much forward to these hearings because I think a great deal of light can be shed on the issue of drug treatment for prisoners.

The bill calls for $75 million which would be split between Federal, State and local areas. But in the budget process we have arranged for $110 million. Now this does not indicate how much it would really cost to treat people in prisons but it is certainly a very important start. It gives us a national and State strategy and it gives us an experience base where we can find out just how much it does cost, where most of the drug crimes are related.

We have 710,000 people in prison in America. It is incredible that we should have to build an additional 250 cells today when we already have coast-to-coast, wall-to-wall prisons. We are actually the most, as Mr. Rangel indicated, incarcerated nation in the world. There are more people in prison now than live in Washington, DC. It is as if every man, woman, and child in Washington, DC were placed into a prison, and then some more. So we can see how much this is costing us. A great deal of crime is drug-related. Most violent crimes are drug-related.

So I think we can get on to the business now of searching out where the most egregious part of our drug problem is. How can we get to the hard-core addicts? How can we make these people safe when they are returned to the streets? How can we help these people lead productive lives? How can we ensure that people will have safe streets in America and that we can get a handle on this drug scourge that we have crossing our country?

I thank you, Mr. Chairman, for having these hearings and giving us the opportunity to listen to these experts today.

Mr. RANGEL. We have with us Tom Lewis, James Inhofe, Howard Coble and James Ramstad. The chair wants to know whether anyone would like to be recognized for a statement.

Mr. Lewis.

OPENING STATEMENT OF HON. TOM LEWIS

Mr. LEWIS. Thank you, Mr. Chairman. I want to thank you for holding these hearings and also my colleague from New Jersey for the inspiration that if you take a poll anywhere in the country, you will find the greatest concerns that most people have are crime.

In Florida, 85 percent of our incarcerations, as will come out in testimony, are drug related. And so I believe that the President's emphasis on crime certainly has merit and we will continue to work toward that.

Mr. RANGEL. Mr. Inhofe.

Mr. INHOFE. No, no comment.

Mr. RANGEL. Mr. Coble.

OPENING STATEMENT OF HON. HOWARD COBLE

Mr. COBLE. Mr. Chairman, very briefly. I am pleased to welcome this group here.

As you said earlier, this town is famous for numbers, for figures. And last week, Mr. Chairman, I was told that we boast 5 percent of the world's population and we use 50 percent of the world's cocaine. I am interested to know if these figures are correct. And perhaps you all may want to touch on that today.

I look forward to hearing from our panel, Mr. Chairman. Thank you.

Mr. RANGEL. Mr. Ramstad.

Mr. RAMSTAD. Mr. Chairman, I don't have an opening statement. But I too am looking forward to hearing from our witnesses. Thank you.

Mr. RANGEL. We are joined by Mr. Clinger.

Mr. CLINGER. Mr. Chairman, thank you. I have no opening statement. I have one I would like to submit for the record, if I may.

[The prepared statement of Mr. Clinger appears on p. 48.]

Mr. RANGEL. Mr. Ortiz, Solomon.

Mr. ORTIZ. I don't have an opening statement. I would just like to welcome the witnesses.

Mr. RANGEL. Well, we are depending on you. We thank you very much for your patience with us.

The chair now recognizes Mr. Robert Aukerman, director, alcohol and drug abuse division, Colorado Department of Health, representing the National Association of State Alcohol and Drug Abuse Directors.

The Chair also welcomes Dr. Douglas Lipton, director of research, Narcotics and Drug research, Inc., New York; Mr. Morris Thigpen, commissioner, Department of Corrections, State of Alabama; and Ms. Kemi Morten, vice president and general counsel of Unfoldment, Inc., in the District of Columbia.

We will start off with Mr. Aukerman.

STATEMENTS OF ROBERT AUKERMAN, DIRECTOR, ALCOHOL AND DRUG ABUSE DIVISION, COLORADO DEPARTMENT OF HEALTH, REPRESENTING THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS, DOUGLAS LIPTON, DIRECTOR OF RESEARCH, NARCOTICS AND DRUG RESEARCH, INC., NEW YORK; MORRIS THIGPEN, COMMISSIONER, DEPARTMENT OF CORRECTIONS, STATE OF ALABAMA, AND KEMI MORTEN, VICE PRESIDENT AND GENERAL COUNSEL, UNFOLDMENT, INC., DISTRICT OF COLUMBIA

STATEMENT OF ROBERT AUKERMAN

Mr. AUKERMAN. Thank you, Mr. Chairman. I am here primarily in my capacity as vice president for drug abuse issues and chairperson of the Criminal Justice Committee for the National Association of State Alcohol and Drug Abuse Directors, although, as you indicated, my primary responsibility is as director of the alcohol and drug abuse division with the Colorado Department of Health.

As has been indicated by members of the committee, we are indeed the most incarcerated country in the world. We have about

426 out of every 100,000 of our citizens behind bars at any given time. That compares with other countries in the world, 97 in Great Britain, for example, and 40 in The Netherlands for the same population numbers.

Of the 710,000 Americans in jail, over 70 percent were arrested on drug-related charges. And as of most recent statistics released in 1988, there were over 1 million adults arrested for drug violations.

The figures continue in a similar vein. Of over 1,600 jails surveyed, approximately only 7 percent of an average daily inmate population of almost 200,000 were enrolled in drug treatment programs.

We have a lot of people in jail. We have very few in treatment while they are in jail. Only 13 percent of the inmate population receives daily treatment.

The American Jails magazine indicates that:

> Despite the high prevalence of drug abuse among inmate populations, and a growing awareness that untreated drug abusers have a negative impact on all segments of society, most jails do not have adequate drug treatment services.

At the present time, it is estimated that only 15 percent of addicted prisoners are receiving any kind of treatment in the Federal and State correctional systems.

The urgency for comprehensive treatment programs throughout all levels of our criminal justice system is reinforced by the fact that most offenders will return to the streets in a relatively short period of time.

If they don't acquire the skills to live an alcohol- and drug-free lifestyle while incarcerated or under the supervision of the criminal justice system, they are much more likely to revert to the behavior that resulted in their initial arrest and pose an increased risk and cost to society.

We must offer drug-dependent offenders the opportunity to recover from their addictions and live productive lives in our society.

The urgency of this situation leads NASADAD [the National Association of State Alcohol and Drug Abuse Directors] to urge that the U.S. Congress formulate a drug treatment policy that will begin to find a solution to these overwhelming problems. We believe the foundation of a blueprint for these policies can already be found.

I would like to take just a minute or two to give you some examples of programs that are already in place and either show very encouraging results already or great promise.

In New York State alone, the annual drug commitments to State correctional facilities between 1984 and 1989 increased about 400 percent. And if these trends persist, the prison population in New York State will rise from a current level of 55,000 to over 71,000 people by the year 2000.

Drug offenders will likely comprise almost 40 percent of all the male inmates. In addition, most inmates at the State and local levels and those under supervision of probation have drug abuse problems. About 74 percent of State inmates are identified drug abusers.

In recognizing the need for special services for this population, New York State has developed several programs.

The Stay'n Out Program, developed in 1977, included the State division of substance abuse services, providing for residential treatment programs within correctional settings; therapeutic communities were established in the Department of Corrections, the Arthur Kill correctional facility for males and Bayview correctional facility for women. In 1988, an additional 35 beds were added to the Arthur Kill facility.

This project has served as a model for other program development and provides primarily a therapeutic community model kind of approach.

There are also programs for drug abusers at Rikers Island. And at the same time that Stay'N Out was implemented in the New York corrections agency, they also took steps to establish their own in-house alcohol and drug abuse program. And the Alcohol and Substance Abuse Treatment Program [ASAT] as it is called, provides a comprehensive range of services from early identification and intervention to treatment, and has grown from initial involvement in one facility to its present level of activity in 60 of the 63 State facilities.

Treatment programming is either residentially based, where the inmates live in a unit separate from the general population and are involved in services for a portion of each week, or conducted on an outpatient basis, where the inmate is placed in the general population and attends regular group therapy and counseling sessions as part of the overall institutional programming. Approximately 21,400 inmates were served in 1990.

In the interest of time, I will quickly mention that in the State of New Jersey there are also several programs for offenders. Nineteen percent of all male adult inmates are involved in a wide range of substance abuse programs in the adult prison system, and many are involved in treatment inside the institution, where programs meet either full time or a minimum of four times per week.

An example of a treatment program in New Jersey, which shows some considerable success, is Persons Incarcerated Entering Recovery, or the PIER Program.

The program is a prison-based therapeutic community at Southern State Correctional Facility in Delmont. The program provides intensive substance abuse treatment services for 90 inmates. The average length of treatment is 12 months.

I think it is significant that the annual cost of the PIER Program is just $4,253 per inmate over and above the normal cost of housing a prisoner. However, since the intent is to provide intensive treatment within the institution, followed with participation in community programs, an avenue is provided for prison release at first eligibility, thus freeing much needed bed space and reducing cost of lengthy incarceration.

There are other examples. Florida is one of the few States that has developed a comprehensive battery of substance abuse services on a statewide basis. The program provides linkages for institutional and community resources and has created new services within the intent of the Florida legislature.

It is estimated that of 44,000 inmates in the Florida correctional system, 85 percent of those are drug-related admissions.

A comprehensive statewide substance abuse program, which includes an initial assessment phase and a tier system offering varying degrees of treatment at various intensities, both in prison and in the community, has been developed and is offered in the State of Florida.

In summary, these programs, and others in various States that you will hear about from the other panelists, lead to, I think, the conclusion that without the availability of effective treatment alternatives in the criminal justice system, the dilemmas facing our society in relation to drugs and crime will continue to grow.

Legislation such as H.R. 730, Drug Rehabilitation and Recovery Program for Prisons, begins to address the critical treatment needs in Federal and State prisons as well as juvenile facilities.

The bill seeks to ensure that the services provided are comprehensive in nature, include a strong aftercare component, and are linked to community-based services. All of those are essential components.

NASADAD would like to recommend the following:

Expansion of programs to identify drug-dependent persons entering the criminal justice system, with appropriate assessments and referral into drug treatment programs;

Expansion of case management programs, such as Treatment Alternatives to Street Crime [TASC] for the assessment, referral and monitoring of offenders in community-based treatment facilities;

Creation of special drug treatment programs to be offered by community-based treatment programs, as an alternative to incarceration for eligible nonviolent offenders;

Expansion of in-prison and in-jail drug treatment programs to be offered by expert treatment personnel and linked closely with community-based treatment and support programs;

And appropriate referral to drug treatment programs for released drug-dependent inmates as well as those who have been paroled or individuals who have been placed on probation.

Thank you very much for the opportunity to testify, Mr. Chairman, before the Select Committee on this very serious matter.

I think statistics show that our prisons and streets are indeed overwhelmed by America's substance abuse problem and just incarcerating or institutionalizing individuals certainly does not seem to be helping.

It becomes apparent that if we are to help individuals change, we have to provide treatment services as well as incarceration.

Thank you very much.

[The prepared statement of Mr. Aukerman appears on p. 51.]

Mr. RANGEL. We will withhold our questioning until we hear from the full panel before us, and further, that you should know that your entire statements will be entered into the record.

I do hope that you will be prepared to answer, if you don't already include it in your general statement, as to what we should be doing, how much it would cost, what will be the cost benefit, and what impact this would have in reducing our prison population.

I think it should be made abundantly politically clear that this Congress and most State legislators are not thinking about what

type of services they can provide to inmates. Whether it is treatment or whether it is rehabilitation, it is not a very popular subject, which should be made clear by some of our reelection statements.

Having said that, if we are concerned about crime, you should tell us, can we reduce crime by reducing the number of people that are going to jail; can we reduce our State budgets by reducing the number of people that return to jail; and can we reduce crime by giving some type of service to rehabilitate these people and get them involved in some legal activities?

Let's hear now from Dr. Lipton, director of research, Narcotics and Drug Research, Inc., New York. Doctor, welcome.

STATEMENT OF DOUGLAS LIPTON

Dr. LIPTON. Thank you, Mr. Chairman, members of the committee. I am Dr. Douglas S. Lipton, director of the Research Institute of Narcotics and Drug Research, Inc. of New York City. NDRI is a not-for-profit corporation and has since 1967 conducted drug abuse-related research and evaluation.

It is a pleasure to appear before you today to testify what our research and our experience show can be done to improve substance abuse treatment within the criminal justice system.

Addiction treatment is a critical component of the Nation's war on drugs, and the incarceration of persons found guilty of various crimes who are also chronic substance abusers presents a propitious opportunity for treatment. It is propitious because these persons would be unlikely to seek treatment on their own, and without treatment they are very apt to continue their drug use and criminality after release. And we now have cost-effective technologies to effectively treat them while in custody and to alter their lifestyles.

I come with the intention of conveying to you the optimism I feel with respect to the number of "irredeemable" persons—namely, chronic heroin and cocaine users with extensive predatory criminal histories—that can be treated effectively.

It is worth noting, Mr. Chairman, that with the high rate of addict defenders, such as the ones I am talking about, who commit 40 to 60 robberies a year, 70 to 100 burglaries a year, more than 4,000 drug transactions a year, just a meager 10-percent reduction in recidivism means a substantial improvement in the quality of all our lives. And we consistently have been able to substantiate more than a 25-percent reduction.

The field of corrections has not had notable rehabilitative successes. And I am partly responsible for the pervasive notion that nothing works, which emerged from a summary written by Bob Martinson of a book that I wrote with two colleagues back in 1975 called "the Effectiveness of Correctional Treatment." So that stands in my credit to be a skeptic in the face of this kind of evidence.

So when I see successful outcomes for correctional programming and I see it repeated year after year with a group of offenders who are unlikely to succeed, it certainly makes me pay attention. And when I say success, I am referring to reducing recidivism to a sta-

tistically significant degree. And by recidivism, I mean returning to prior forms of conduct.

So I not only want to share with you the success of the Stay'N Out project but also of other programs that have been successful with drug-abusing offenders.

Now you have heard and others will testify to the extent of the problem. It is contained well within my statement that has been submitted. So I am not going to go into detailing the extent of drug abuse. All of you are very, very familiar with it.

The current costs are clear. We all know about the overcrowding problem and how much drug abuse is driving the overcrowding, and the consequence of only eight States left in the Union who are not under some kind of court order or consent decree to relieve this prison crowding.

So anything we can do to relieve this pressure by in fact treating people successfully will be of benefit not only to the public in terms of reduced crime and reduced drug abuse, but also in terms of reducing the prison overcrowding.

Very few inmates, despite the demonstrated need for treatment services, actually receive treatment for their addiction, either before, during or after their incarceration. The DUF data show that on the average only 4 percent of arrestees are receiving treatment at the time of arrest and about 22 percent of arrestees have ever received treatment.

Recently we did a survey in New York City, as part of the Pathways into Treatment project, and we found that 70 percent of the active heroin and cocaine users had never been in treatment and had no current intention of ever entering treatment, although some had experienced detoxification.

It can't be underscored enough, how much leverage you create by incarcerating someone and offering them an opportunity for treatment which otherwise they would never experience.

In 1987, the estimates showed that about 11 percent of the inmates in the 50 States were in drug treatment programs. The vast majority of inmates with substance abuse problems still do not receive treatment while in prison. And in fact, if you begin to look at that treatment, you will find that the bulk of it constitutes 1 hour or 2 hours a week group counseling, which has been demonstrated over the years not to be successful.

Now 39 States use some kind of preliminary assessment, some kind of diagnostic procedure; 44 States allow Narcotics Anonymous, Cocaine Anonymous, or Alcoholics Anonymous to operate within their institutions, hold a meeting once or twice a week; 44 States have some kind of short term, 35- to 50-hour drug education program.

I would submit to you that later on in my statement, which I won't get to today, the point is well made, I think, that involving people who are essentially sophisticated drug users in drug education programming by persons generally who know far less about drugs than they do does not utilize time very well.

TREATMENT WORKS

Prior to 1980, relatively few outcome research studies of therapeutic communities in prison settings had been conducted. Although I must say that over the last 25 years there have been quite a few TC's in prisons, the average length of time of those TC's, those therapeutic communities, was about 6½ years. Most of them that ended their tenure did not end because they failed or because they succeeded. They ended because a new warden came in who felt that vocational programming was a better use of time or because of administrative or fiscal cutbacks.

I want to tell you about the Stay'N Out Program and the Cornerstone Program.

The Stay'N Out Program is a therapeutic community in New York. Bob Aukerman just mentioned it. It exists at two institutions.

There is a program for about 140 inmates at Arthur Kill, for males, and there is a program for about 40-odd women at Bayview, which is a correctional institution for women in New York City.

Stay'N Out is a therapeutic community for the treatment of incarcerated drug offenders, most of whom, almost all of whom are predatory heroin and cocaine users.

These programs have been operating at Stay'N Out since 1977 and we have—that is, NDRI has been evaluating that program since its outset.

In 1984, we received a NIDA grant to evaluate Stay'N Out and compare it to other prison drug abuse treatment programs. So, building on the data we had been collecting and doing some intensive interviews, we conducted a large-scale quantitative analysis. And we looked at a variety of measures of treatment outcome.

We looked at both males and females and we compared the people who went through Stay'N Out with people who went through milieu treatment, like the ASAT Program Bob Aukerman mentioned, to people who went through group counseling, and people who went through no treatment. We did it for males and we did it for females. And we examined it in terms of the length of treatment, because the experience with therapeutic communities is that the longer they are in treatment, the better the outcome.

What we found was that not the longer the treatment, the better the outcome, but that people who had been in treatment for 9 to 12 months had been statistically significantly successful time after time, cohort after cohort, to the point where 77 percent achieved success with no return after 3 years.

We did 9 years of follow-up and the results are, in my very skeptical view, unequivocal. That we are able to achieve this result again, and again, and again, with group after group after group that went through, indicates a very high level of consistency that this program is able to achieve in producing that level of result, in comparison to the three control groups that I mentioned to you.

Mr. RANGEL. I am sorry, Dr. Lipton. I missed it. How long do they stay out of jail?

Dr. LIPTON. Seventy-seven percent of them had no parole revocations, no rearrests, no reconvictions, no reincarceration of any kind for 3 years. We followed all inmates who had been through all of

the programs, treatment and control, for 3 years. We followed most of them for 6 years, many of them for 3 years.

Mr. RANGEL. What was the result within 6 and 9 years?

Dr. LIPTON. The result was that this group, although you had some diminished effect over the years, remained drug free and crime free over the span of the time after they had left the program. So that we experienced a level of outcome which is rarely seen in correctional treatment. And this is in contrast to the milieu therapy, which is somewhat like a TC but less——

Mr. RANGEL. I am missing something. Seventy-seven percent stayed out of jail for 3 years?

Dr. LIPTON. Yes, sir.

Mr. RANGEL. What percentage stayed out after 6 years and 9 years?

Dr. LIPTON. Well, it is a different pool of people. So I wouldn't want to confuse the issue.

Mr. RANGEL. Well, does it get worse?

Dr. LIPTON. Some are slightly worse, yes, sir, but very, very little.

Mr. RANGEL. OK. I am sorry to interrupt.

Dr. LIPTON. What you do is sustain the effect much, much longer. And even for those who fail, the ones who went through Stay'N Out for 9 to 12 months were able to stay out significantly longer than those in the other groups.

The main finding is that maximum reductions in recidivism occur for those inmates spending 9 to 12 months in programming. And for females, 92 percent success was achieved, also for 9 to 12 months.

So we have an optimum period of treatment and that effect seems to be sustained for a long time, much longer than anyone anticipated at the beginning.

Now the interesting thing is that this is a robust conclusion. It is highly reliable over time. And they are more likely to succeed if they stay in the program 9 to 12 months than if they stay less or if they stay longer.

Mr. RANGEL. If you have it, Doctor, the 77 percent sounds great to me, but compared to what? If you don't do anything, what is the percentage that return? Do you have that?

Dr. LIPTON. The number of people in the control group that has received no treatment and those who are in the once a week or twice a week counseling group, 60 percent of those return. Of those who are in the milieu therapy, about 50 percent return. So you have about 27 percent better than any other control population.

Now what I want to do is also point out that Cornerstone, a program very similar to Stay'N Out in Oregon, treating inmates who are in fact very, very similar, also predatory heroin and cocaine users, achieved almost identical results.

So here we are all the way across the country with people from a very different kind of state, where they only have 9,000 inmates total in all their institutions, producing very similar outcomes. This tends to support the validity of the finding from New York.

Now these are the first large scale research evaluations to provide solid evidence that prison-based therapeutic community treatment can produce significant reductions in recidivism rates among chronic drug abusing felons.

It is worthwhile noting that the success of this type of holistic treatment is probably due to the fact that it deals with many of the social and psychological impediments to returning to acceptable social functioning that inmates possess. It deals with the myriad problems associated with the lifestyle of addiction as well as the drug use, and is therefore more likely to be successful in the long run than treatment programs that focus mainly on drug abuse.

The cost effectiveness of the treatment makes the case for implementing such programs even more imperative. Programs like Stay'N Out cost about $3,000 more than the standard correctional cost per inmate per year. Programs like Cornerstone, with more professional staff and one-fourth the caseload per staff member, cost a little over twice as much for the same time period. The savings produced, however, in crime-related and drug use-associated costs pay for the cost of treatment in about 2 years for Stay'N Out and about 3 years for Cornerstone.

It is an inescapable conclusion that treatment lowers crime and health costs as well as associated social and criminal justice costs. Moreover, the higher the investment in rehabilitating the most severe offender addicts, the greater the probable impact.

The most serious chronic heroin and cocaine users, which represent only between 3 and 10 percent of all serious offenders, depending on the jurisdiction, are each responsible for a very high volume of predatory crime. Any substantial reduction in such criminality among this group immediately has an impact on our quality of life.

Without intervention, this group will return to crime and drug use 9 times out of 10 after release, and most will be back in custody within 3 years.

With appropriate intervention, more than 3 out of 4 will succeed. That is, reenter the community and lead a socially acceptable lifestyle. This highly predatory group is amenable to long-term, nine- to 12-month, therapeutic community treatment while incarcerated, and is unlikely to benefit much from less intensive treatment.

Now Project Reform is a project that I was conational coordinator for, for a number of years. This program disseminated the results I have just spoken about as well as all kinds of technical assistance with respect to drug abuse treatment for incarcerated offenders, and generated interest in many States to undertake drug abuse treatment and correction.

In 1987, the Bureau of Justice Assistance of the Department of Justice awarded a grant to NDRI, my organization, to initiate Project Reform, which provided this technical assistance to State departments of correction to help them plan statewide comprehensive drug abuse treatment for correctional inmates and implement the plans that developed.

In the two years that NDRI's Project Reform was in operation, 11 State departments of correction, including Alabama, California, Connecticut, Delaware, Florida, Hawaii, New Jersey, New Mexico, New York, Oregon, and Washington, received technical assistance to develop or enhance their comprehensive prison-based drug abuse treatment from our technical assistance and training team.

Commissioner Thigpen and I met during that period—before the program ended we assessed how much programming was implemented by the reform States in just 8 months of implementation

time. And what we found was, without going through all the details, an enormous amount of programming in place.

We continued this. We did some more technical assistance with a 3-day workshop in June 1990, about a year ago, in Colorado. Bob and I met there. North Carolina, Virginia, Georgia, Michigan, and Pennsylvania were involved.

The program has moved from BJA to OTI. OTI, using the great leadership of Dr. Beny Primm, has eagerly picked up the program. And its leadership, the specific program's leadership by Nicholas Demos, a very unusually dedicated public servant who ran the corrections program for BJA, is now running it for OTI. And OTI awarded an 18-month contract to us to continue the Project Reform work.

Its new name is Project Recovery. And the States that are involved are Alabama, California, Colorado, Connecticut, Georgia, Hawaii, Michigan, North Carolina, North Dakota, New Mexico, New York, Pennsylvania, Virginia, and Washington.

Besides providing technical assistance, we will be providing a number of other services; drug abuse-related technical assistance materials, manuals, and so forth.

The experience that we have gained—and I think it is very, very much on target as to what your question was—is that among correctional administrators and even among the public there is a strong interest, lying dormant for about 15 years, a strong attitude in support of rehabilitation, as opposed to incapacitation and punishment.

There were many more applicants for BJA's Project Reform program and for the OTI funds for this program from the various States. And what is amazing—I really think it is amazing—is that the Federal portion amounted to about $500,000 per State in both planning and implementation funds. The States, in consequence, without being required, have appropriated as much as 10 times as much out of their tax levy moneys to make the programs happen, in the first year alone. And they continue to do so afterward.

So for the Federal investment of $5 million, a great deal of programming was generated in the States. And our current examination of the program's accomplishment reveals that most States have expended or pledged far more funds, staff and programming for drug abuse treatment in corrections than had been foreseen when plans were drawn. So the effort has been, for the most part, very catalytic in generating development in this needful area.

The OTI's current commitment of $4 million for this purpose will allow the mission to continue, but at a very slow pace.

The proposed legislation, H.R. 730, does in large measure speak to this national need. And I heartily endorse the intent of the bill and the dollar amounts proposed and, without detail, support the recommendations that Bob had read to you from his notes. But given the vast numbers of incarcerated drug abusers, it will only begin the process of bringing these predatory persons to recovery.

Nonetheless, by concentrating on these offender addicts, the effort will undoubtedly be quite cost effective, a salient factor in the public's view.

It is my hope that my testimony today will encourage this committee's consideration of expanding this program to provide funds

to stimulate planning and implementation for correctional drug abuse treatment to all the States, following the BJA model, the OTI model that has been so successful.

I have only two concerns regarding this bill. In section 577(b)(4)(a), I would recommend altering the urinalysis requirement to a much higher rate and then diminish the rate over time, which is expressed in detail in my printed remarks. And I would also recommend adding a requirement for evaluation research, allocating about one-half million dollars per year to measure the process, implementation and outcome of the efforts undertaken by the States under this legislation.

There are no persons in senior policymaking positions, as well as in academia, who could not agree that rehabilitation is or should be one of the key purposes of the postadjudicatory system. If it comes down to a matter of opinion whether the State has a responsibility to undertake correctional rehabilitation, I certainly will firmly declare for it. The empirical evidence unquestionably supports its utility.

I assert that the Federal Government and the States have both a responsibility to encourage and sponsor rehabilitation for addict offenders, and a significant opportunity to do so by doing it in a correctional setting.

Three balanced purposes can and should be effectively and simultaneously served: punishment through individual deterrence, direct preventive force by incapacitation, and retention for prosocial change or rehabilitation.

In summary, I believe that just serving time inexorably degenerates both the inmates and their keepers. I believe that we should use time as an opportunity for change. It values both of them, and eventually alters the quality of life for all of us.

Thank you for the opportunity to share these insights and thoughts with you. This concludes my testimony. I will be pleased to answer any questions that you may have.

[The prepared statement of Douglas Lipton appears on p. 69.]

Mr. RANGEL. Thank you, Dr. Lipton. We will reserve questions, but I do hope that you get together with Mr. Guarini to make certain that he can share the benefits of your research and get broader support for his legislation.

The Chair also would like to recognize the presence of experts in this field.[1] We are glad you are here.

And now we hear from Commissioner Thigpen, of the Department of Corrections, State of Alabama.

STATEMENT OF MORRIS THIGPEN

Mr. THIGPEN. Thank you, Mr. Chairman. Let me first of all just emphasize a couple of points that Dr. Lipton made that I think undergird probably my whole testimony. That has to do with the purpose of corrections.

I think certainly today, within the corrections field, most of the correctional administrators will acknowledge that we have more duty than just punishment. And I think most all of us are seeking

[1] Pat, Lucy, and Kathy O'Hara from Florida.

ways of improving programs within our systems, so that we can create an environment that leads to positive and noncriminal behavior.

I feel very strongly that most inmates will respond to a positive environment when treated with dignity and respect. Like every other human being, they can radically change, given the right conditions and their own personal motivation.

About 2 years ago, we started collecting data as part of our intake process in an attempt to determine the extent of substance abuse among the inmates in our system. We found that about 80 percent have significant abuse histories. We also found that about 20 percent report that they have used frequent drugs IV.

We feel like that is given additional emphasis by some of the drug use forecasting project work that was done in Birmingham, AL, where it shows that 75 percent of the felony arrestees tested positive for drugs. And of those testing positive, almost 50 percent were positive for cocaine.

In looking at these histories, we find, as has already been pointed out, extensive burglary, shoplifting, receiving stolen goods, dealing drugs, and prostitution, as well as violent crimes of robbery and murder.

We also have found, in looking at these case histories, that almost one-third of our admissions coming into our system in Alabama are failures from community-based programs. These would include supervised intensive restitution, probation and parole, and other type programs at the community level.

About 64 percent of those returning from these community-based programs are related in some way to substance abuse. Just in the first 3 months of this year we have seen, of that number returning from community failures, about 58 percent have had some involvement with cocaine in some form.

Looking at all of this, we decided that we needed to declare war on drugs within the correctional facilities of Alabama. We felt that the first step necessary in doing that was to try to establish, as much as possible, a drug-free environment within our prison system.

We have a rather extensive program of random drug testing that occurs, using urinalysis. We have eight automated stations within our system that do about 10,000 tests monthly.

We now can show, by this random testing, that we have below 1 percent positive tests showing up within our inmate population. At one time, in some of our institutions, that would run as high as 12 to 15 percent.

We also incorporated in our program of testing something that has been somewhat controversial but I think is still a very valuable tool, in that we test the security officers in our system on a random basis. That again is part of creating a drug-free environment.

During the period of time that testing has been in operation, we have terminated about 12 to 13 officers because of the positive tests that were found.

Treatment programs became a major effort in attempting to provide a program within our system. Of 14 major institutions, 6 now have substance abuse programs. This was made possible through a BJA block grant that was made to us, and we are very appreciative

of that funding. Without it, I doubt that these programs would have been initiated.

Recently, we have also been able to take one of our new facilities, the Ventress facility, which is located at Clayton, AL, a facility with about 620 beds, and we have dedicated its primary mission as substance abuse treatment. Through a grant from the Office of Treatment Improvement in the amount of $841,000, we have turned that prison into a total treatment facility.

The use of therapeutic communities within prison settings has also been mentioned. We now have two of those programs, one at Ventress and one at St. Clair, which is a maximum security facility just northeast of Birmingham. There, in that maximum security facility, we are working with long-term inmates.

This goes somewhat against the trend that we have seen in recent years, because many advocate that drug treatment needs to be tied in with that period of time just prior to release. But within this therapeutic community at the St. Clair facility, we are even working with some inmates who have life without parole sentences.

We feel that it is important that we have seen some excellent results coming from that particular facility.

Some might question the advantages of substance abuse treatment in prison.

First of all, I think some would argue it may not be the best location. And that certainly is valid. But I think it does offer some advantages, which we all need to take note of.

First of all, within the prison system, I think it is obvious that we probably have the greatest concentration of substance abusers that I know of in any one location.

I think through the prison treatment programs we will reach abusers that will never walk into a free world treatment program, nor could most of them ever afford such treatment.

There is within the prison system a high degree of control. That will enable us, I think as we have shown, to create a relatively drug-free environment in which these treatment programs can take place.

It also is a situation in which the client can't leave the program when the going gets tough. And in drug treatment, the going does get tough at times.

It is also easier to hold people accountable within the prison facility.

I think it has been pointed out, and I am sure it will occur as you hear other testimony, that within the prison system it can be very cost-effective.

We estimate that the 8-week program that we conduct for many of our inmates at the Ventress facility and other facilities probably adds only about $400 to $500 additional cost over the costs that are already borne by the State. A similar type of program in the free world would literally cost thousands of dollars and would not be available to most of these inmates.

Also within the prison facilities, I think you would find that there is no stigma attached to treatment programs for substance abuse, as is sometimes found in the free world.

Dr. Bennett, in a white paper in June of 1990 called "Understanding Drug Treatment," pointed out, and I quote from his introductory remarks:

> * * * personal accountability and adherence to rules that pervades the criminal justice system is frequently a part of effective drug treatment. Good treatment programs insist on a code of conduct, individual responsibility, personal sacrifice, and sanctions for misbehavior. There is now an impressive amount of evidence to suggest that when drug treatment contains these elements, we get results: addicts change their self destructive pattern of behavior and stop or dramatically reduce drug use. That is why drug treatment and criminal justice must be understood as allies in our fight against drug use.

Mr. RANGEL. What Dr. Bennett wrote those meaningful remarks?

Mr. THIGPEN. Dr. William Bennett, the former drug czar.

Our experience has shown that within our treatment dorms, whether it is in the therapeutic community or the shorter term 8-week program, those treatment dorms become the quietest, the cleanest and the most disciplined units within the prison setting.

I think it just bears out that old saying that many of us follow that "good treatment is good security."

You had raised, Mr. Chairman, the question earlier about substance abuse, whether it plays a major role in the criminal behavior. My experience down through the years is it absolutely does.

I have literally known hundreds of inmates who never pose any problem within the prison setting or outside the prison setting as long as you can keep them from substance abuse.

But when becoming addicted and involving various addictive substances, then their whole behavior pattern changes.

So I think if we can intervene in that and break that cycle in some way, it most definitely can have a positive result in reducing the number of people coming into our system.

In terms of where I would like to see some additional emphasis given, one of the things that we face that poses a serious problem to our efforts is the fact that we find it very difficult to get the follow-up treatment services once an inmate leaves the prison setting.

I know that it is not popular to talk either at the State or national level about earmarking funds for jail and prison treatment programs. But I want to go on record as recommending that strongly, because it is simply difficult to get a lot of times the follow-up that we need in the community.

There also needs to be a concerted effort to provide funds for research. You rightfully have asked every member of this panel in terms of what is the experience, what is working, what is not working.

I am not sure in every case we have an answer to that. We are certainly trying to identify every one of our inmates who goes through some sort of treatment program, so that long-term research can take place, simply to see what is working and what does not work.

We also need additional help from the Federal Government. In Alabama, we still have about 2,000 inmates that are identified and awaiting substance abuse treatment services that are not receiving them at this time.

One of the visitors to our therapeutic community posed a question to a life-without-parole inmate about what difference drug treatment makes for him. He stood up and looked this person square in the eye, and he said:

> You know, there are two kinds of prison, there is the physical and the mental. The sentence that I am under means that I will spend the rest of my life in the physical prison. But this therapeutic community has freed me from the mental prison that I was formerly in.

I thank you for the opportunity to appear before you. I thank you for the assistance that is being given by the Federal Government through numerous agencies to our efforts within the prison, and certainly would encourage the expansion of those efforts. Thank you.

[The prepared statement of Mr. Thigpen appears on p. 106.]

Mr. GUARINI. Thank you very much.

I would like to call on Ms. Kemi Morten, who is the vice president and general counsel of Unfoldment here in Washington, DC. I understand you have members of the family with you. We would like them to stand up in the rear, if they will, and give us some support. Will they please stand?

These are the members of the family that we will be talking about. [Applause.]

Mr. GUARINI. We welcome all of you here. You have a great support team and we are very interested in listening to your testimony. Will you please proceed.

STATEMENT OF KEMI MORTEN

Ms. MORTEN. Thank you very much. Good afternoon, distinguished members of the Select Committee on Narcotics Abuse and Control. I am very pleased to be here today on behalf of the board of directors of Unfoldment to express our full support for the speedy enactment of H.R. 548 and 730.

Unfoldment, Inc. was founded in 1977 by my father, who is seated here with me, Baker E. Morten, a veteran journalist, primarily to heal criminal impulses among troubled District youth. For the last 14 years we have done just that by working with more than 5,000 young people in the southeast, Anacostia neighborhood of Barry Farms, which is one of the city's largest public housing projects. We work in the areas of reading and math enrichment, and drug education and prevention.

In 1989, we really had no thought of providing drug treatment services to Lorton inmates. However, we were contacted by members of the Twelve John Does Inmate Mission, a group of Lorton inmates who, with the help of the law firm of Covington & Burling, filed a successful suit against the DC Department of Corrections to improve conditions at the prison. By this time, fines had mounted to millions of dollars for failure by the District to correct these conditions.

And I might add, that when you think about the millions of dollars that are lost in prison conditions lawsuits directly due to prison crowding, and the extent to which programs such as ours reduce recidivism, crowding, and lawsuits, there is a savings that

we need to consider so that the cost effectiveness of prison-based treatment is increased.

Instead of funneling the fines back to the Government, U.S. District Court Judge June L. Green, through her special officer, the late Judge John Fauntleroy, asked the inmate mission how it wanted the money spent. The men themselves requested the creation of two programs, our program, Unfoldment, which is now the largest residential therapeutic drug treatment program at Lorton, serving over 100 men at the central and minimum facilities, and a job training program operated by LEEO [Liberation of Ex-offenders through Employment Opportunities].

We have been judged successful by many experts in the field who have visited our program, and much of the credit goes to the many people who are listed in my statement.

I would like to, in the interest of time, get straight to the kind of approach that we use at Unfoldment, that we think really works. In doing so, I would like to associate myself with the remarks of my colleagues of the panel and particularly Commissioner Thigpen.

I really relate to the concept of treating people with dignity and respect. As a matter of fact, we have a sign in all of our dorms that says, "we will treat you with respect, concern and understanding, but don't worry, you'll get used to it." And sure enough, the men get used to it and begin to practice those values among themselves. How do we achieve success?

First, we give preference in hiring to recovering addicts and former prisoners. It was really interesting when we wrote the job description for our program treatment specialists. We sent it around to all of the NA and AA fellowship groups, and it said that we want people who have been clean at least 3 years and we are giving preference to former prisoners, alcoholics and drug addicts. It really worked. We received a tremendous response from recovering men and women who wanted to give something back.

We think that approach works very well, because it is very, very hard for people in white coats, who have never had the agony of a drug experience, to relate to men and women who have. Addicts just run circles around people like me—squares like me.

Much of our success has been due to Unfoldment's outstanding hard-working staff, many of whom are also present today.

Third, our program is based on the 12-step philosophy of Narcotics and Alcoholics Anonymous. We chose this low-cost method of treatment because it is freely available to the men when they come out of prison. Thus they will not have to worry about finding the means to continue treatment with a psychologist every week at $90 an hour.

We also emphasize that the men take responsibility without authority—that is a classic TC [therapist community] concept—in that the participants run the day-to-day operations of the program under the supervision of Unfoldment professionals.

We also consider ourselves to be a family, including the staff, so that there are no big "I's" or little "you's." We also encourage the men to make amends with their biological families through our family therapy program.

We all know that the educational situation facing incarcerated populations is critical in this country. In the District, 50 percent of

all prisoners have not completed high school, and many of them read at a third grade level.

So we require our participants to enroll in a daily structure of educational, vocational or ABE [adult basic education] courses. We supplement this with a culturally relevant curriculum. We offer AIDS education—and by the way, AIDS is a real big issue in dealing with this population. Many of our clients, because they have been long-term heroin users, are HIV positive. Therefore, we offer them and their families special counseling. There are a host of medical issues that they face, and medical costs that increase the costs of incarceration. Beyond AIDS education we offer courses in nutrition, morals and values, relapse prevention and group and individual counseling.

Our admission criteria are very simple. We require first, that an inmate acknowledge that he has a problem, which we classify as the disease of addiction, and that he be willing to heal himself.

Also, the inmate must be within 5 years of parole eligibility and be willing to isolate himself for 90 days from all visits, telephone calls, the general population and television and radio.

While we require this 90-day isolation period, we feel that at some point program participants should be required to mix with the general population, in order to take advantage of educational opportunities provided by the department and to test the strength of their recovery.

We isolate them because drugs are readily available, unfortunately, at most prisons, and certainly at Lorton. Recently one man came to me on the compound and said, "Ms. Morten, I have got to get into your program." And I said, "Well, why." He said, "because last night I went to the rest room and there were three men sharing a needle in the bathroom and blood was all over the floor, and I just realized, I have got to stop doing this. I need help."

When you think about the AIDS epidemic, you think about the fact that these men are not going to come back in isolation. They are going to come back to families, children, wives or girl friends. Then you think about the health cost of AIDS, and you really have to acknowledge the need for these kinds of prison-based programs.

Our approach using recovering addicts, we believe, is more cost effective than the medical approach of using doctors, psychiatrists, and other professional managers. On those occasions that we need those services, we obtain them on a consultant basis.

We also include mandatory conflict resolution techniques in our methodology to address the issues of senseless violence facing this population. I am pleased to note that we have been very successful with our violence therapy work. Over the last 15 months we experienced no disciplinary reports, nor assaults on staff or residents.

And so, with that program in mind on March 1, 1990, we opened our doors in the middle of what was then a dirty, dilapidated warehouse at the central facility. The first class of men arrived, really, with bundles of their sole worldly possessions, kind of expecting everything to be laid out for them. They were very surprised when they asked me what was going to happen because I turned the question around and said:

Why don't you give me your recommendations of how we should turn this into a first-rate treatment program. Break yourselves down into committees and let me

have a budget of what you need to paint this place and what supplies you need to fix it up.

Many of these men had never made those kinds of decisions in their lives. Many of them had never had checking accounts. Many of them had never paid a phone bill or a gas bill. For years they had lived a totally different lifestyle. So it was quite challenging and interesting, the first 90 days.

But the men did transform that building into what is now the cleanest, safest, most quiet dorm at the DC Correctional Complex. They learned responsibility and we learned a lot, too.

We learned that it is not just the addiction to drugs that is the problem. There is what we call an addiction to the lifestyle for all of the men that we serve. When we say addiction to the lifestyle, we talk about immediate or instant gratification with no means to achieve it. This lifestyle says: "I want the big car, I want the gold, I want all of the accoutrements of a materialistic society, I want all the things I see on television, but I don't have the education, I don't have the wherewithal. So I am going to go out and do it however I know how to do it," which usually results in drug distribution, crime and predatory conduct.

This lifestyle addiction, which accumulates over a period of time must be countered and healed during treatment or it will manifest again upon release. We use our staff of recovering addicts, who also lived that lifestyle, to serve as powers of example to show the men how to slow down and listen to somebody else for a change. We will advise them to develop long- and short-term goals, which for them appear tedious and unattainable, and together we can come up with a realistic way of achieving those goals. It takes a lot of encouragement, care and intensive 1-on-1 counseling.

The prison setting is perfect for that, because it gives us the kind of leverage that we need to make the men sit down and focus on the things that we are talking about. After a while, the men want to focus. They become willing to do this on their own and that is when the magic begins to work, I think.

We also learned about a phenomenon that we call institutionalization that compounds the twin problems of drug abuse and lifestyle addiction. When you place a person in public institutions and dysfunctional families and neighborhoods for years at a time, they become institutionalized. In prison, Corrections extends the problem and unwittingly fulfills what we call a misguided parental role, by not requiring inmates to program while locked up. Instead, in an effort to keep the assaults and the behavior under control, corrections allows them to sleep and watch television all day, and drug abuse flourishes. It is not a willing thing. I don't want to give the impression that management willingly and knowingly does this, but this is simply the effect of not having meaningful therapeutic programs in prison. Corrections then creates utter dependency by providing food, shelter, clothing, and medical care for this basically dormant population, such that when they leave prison, like a spoiled, irresponsible, and dependent child, many inmates are released socially disabled.

That is one of the problems we are finding in our after care component, as we deal with the problem again of parolees who simply

have not had the experience of functioning in a square, 9-to-5, pay your bill, go to work every day environment.

Prison life is extremely unnatural. And to put someone in prison for long periods of years with absolutely no drug treatment is actually counterproductive, let me just put it that way. I have some examples of that in my testimony.

We also learned that many of the men suffer from the dual diagnoses of substance abuse and psychological disorders that require mental health treatment. In many cases the men were either abused as a child, lived with alcoholic and drug-abusing parents, or suffered the effects of traumatic childhood experiences.

I am not trying to make excuses for any of this conduct, but in order to be effective, we have to consider the multitude of other factors that lead to the first drink or drug.

A perfect example is the case of a man in our program who, at the age of 9 years old, along with two smaller siblings, witnessed the fatal hanging of his mother by drug dealers. It was shortly after this horrifying experience, and because help was not readily available, that he began using drugs and was later arrested for distribution. His brother and sister also have substance abuse problems. Cases like this are not unusual among prisoners. But help is available and healthy lives can be restored through treatment.

There is also very good news that I bring you today. On March 1, 1991, 95 percent of the participants successfully completed our program. They completed it with no dirty urines and no disciplinary reports, a feat that is unheard of in a 62-man medium security dorm.

And while that sounds real good, the true test of any prison-based program, is how well the person does when he leaves prison.

In order to give them a practicum in living life on life's terms, we offer a continuum of services that we call after care and we offer that on three levels:

One is at the minimum security facility, for men who are within 2 years of parole; the second is at a community-based halfway house provided by the Department of Corrections for people who are within 6 months of parole; and then, based on the Oxford House model, we are providing our first Oxford House setting in the community.

In each of these after care settings, the men are required to give back to the community by rehabilitating community properties. And right now, 15 men in our program are currently renovating a building that was formerly an abandoned crack house in far Southeast as part of their way of getting involved in positive civic activities.

Our program then is the District's first effort to provide a continuum of support to this population, and we cite several milestones of success that also go to the cost issue that the chairman has raised today.

Recently, in a case involving simple possession and distribution, U.S. District Court Judge Louis Oberdorfer cited our program as the basis for departing downward from the Federal Sentencing Guidelines for an Unfoldment participant. We have a copy of that case beginning on p. 128.

Also, D.C. Superior Court Judge Sylvia Bacon, in February of this year, reduced the sentence of one of our participants, citing our program as the basis for her action.

Correctional officers, who are usually pretty cynical about programs in prisons, overwhelmingly support our program. In fact, they compete to be assigned to our dorm, due to the cleanliness and the respectful demeanor of the participants.

Also, the department has a CAC [certified addiction counselor] training program that the correctional officers can fulfill practicum requirements for with our program.

We have been asked by the Department of Corrections to expand our program from 60 to 240 beds next year. But funds are a problem.

We support bills H.R. 730 and 548 and we do respectfully suggest a number of amendments.

First, we would suggest that the legislation mandate that prison-based drug treatment be provided by community-based nonprofit organizations. Where such programs are administered by corrections personnel, it is very difficult for the inmates to develop the kind of trust that is needed to make the program work.

We also discourage corrections-administered treatment programs because it is difficult for correctional and security professionals to implement the philsophies of a successful treatment model, because these may differ with department regulations. Corrections officials are trained differently than treatment specialists and it is hard to change the effects of such training.

We would ask that the legislation allow for the direct allocation of funding from the Federal level to appropriate nonprofits, such as the Mount McGregor Program, the ASAT Program that was referred to earlier by the panelists, and also to the halfway house programs.

We would recommend inclusion of language to encourage the development of Oxford House-type programs for parolees who, because of their sentence structure, would not have the benefit of halfway house substance abuse treatment after prison.

We would also ask that funding be earmarked for women and female juvenile offenders. We certainly appreciate the bill's recognition of the great need for treatment among juvenile offenders. But with the crack epidemic, we are noticing a tremendous increase in the number of women, pregnant women, and pregnant juvenile females in the system. Unfortunately, when money is added in a lump sum, women usually come out in this particular field the losers. We would ask that the bill be amended to specifically earmark funding for women amd female juvenile offender programs.

I concur with my other colleagues that funding should be included for research and evaluation.

And with those remarks, I thank you again for being able to share my testimony with you today.

[The prepared statement of Ms. Morten appears on p. 113.]

Mr. RANGEL. Let me thank the panel and all of those down here wrestling with this problem; this has been really the most enlightening testimony I have received. And this is what I call a ray of hope. And what really pleasantly surprises me is the agreement that exists among the panel. We don't find a bunch of Ph.D.'s with

a whole lot of cockamamie ideas that we don't know whether they are effective or not.

So what I do hope is that you keep yourself intact. And I am going to ask the committee to invite you to an informal session with the members of the subcommittees of jurisdiction, to see whether, members and staff, we can work out a bill that, with your help, we can get a broader based support, because I think that what all of you have done, one way or the other, is emphasize what society really saves by making these types of investments, and that is very important.

We have been joined on the committee by Congressman Shays, Congresswoman Lowey, Congressman Gilman, and Congressman Oxley. And I would now at this time like to recognize members for the purpose of asking questions.

Mr. COUGHLIN. Thank you, Mr. Chairman. This has been excellent and very thought-provoking testimony.

It is beyond my ability to understand how an institution that is designed to provide security and to prevent contraband from coming in, ends up being a sieve for drugs. I don't understand how this has happened.

I am also interested in your views on the effectiveness of mandatory treatment in an incarceration setting because treatment in some way seems to imply a voluntary cooperation and not a mandatory kind of setting. This may be a complicated question, but are you just treating what might be considered the cream of the crop in the incarcerated setting and being successful with them? When you get to those who may be illiterate or may require other things before you can even start to think about treatment, do you have the same success stories?

Those are my two questions and I would like to address them to Ms. Morten, in particular, and to any others who might respond to them very briefly.

Ms. MORTEN. That is a great question and I can understand your desire to provide treatment to everyone. We would, too. We would like to mandate treatment.

But we have been approached by judges who have said, "Shall we sentence people to your program?" And we say, "Please don't, because treatment, effective treatment, is really for those not just who need it but who want it. If there is no willingness there, what you will have is a person who is dissatisfied in being in your program, who runs around and talks the program down and discourages other people from making the most of a good situation."

So if there is no willingness, it is hard to do any work in this particular area. But I assure you, we have a waiting list of 500 people who are willing, and we only are currently offering about 120 beds.

Dr. LIPTON. Mr. Coughlin, there is not enough treatment for volunteers. If we are going to start mandating treatment, we are going to run out of people who are trained to give treatment very quickly. That is one of the big problems. If you get people excited about doing treatment, then you have to start implementing it by finding trained staff and people willing to do it.

It has been our experience that the programs that are really at the top of capability of producing success are those that have suc-

cessfully treated former ex-offenders, ex-addicts who are now graduates of programs. These people make excellent treaters but it is very hard for them to work in a prison environment. The environment is a very suspicious one, more suspicious perhaps of ex-offenders than they would be if they are not.

But more than that, in our research, we looked at that specific question of why did people enter this program. And 60 percent of the successful people, 60 percent of the successes entered the program for nefarious reasons. That is, because they either thought they could get by, get over with parole better, or they could have better clothes, or it is a safer environment.

In other words, they didn't enter the program with any motivation to change. They didn't enter it with the intention of getting better.

So in a sense, what you do is, rather than force people into programs which they may or may not necessarily want to go into, you create sufficient incentives so that they will enter it, regardless of their motives. Once they are in, the program is sufficiently powerful to overcome those initial negative motivations, in fact turn most of them around.

So I think that is a significant difference and a very important distinction to keep in mind.

Mr. COUGHLIN. Yes, Mr. Thigpen.

Mr. THIGPEN. I want to address the question about whether we are working with the cream of the crop or not.

In the facility that I described, the St. Clair facility, which is one of our maximum security institutions, in the therapeutic community that is located there, most of those inmates are among some of the toughest that we have in our entire system. Most have been in and out of the system numerous times.

As I stated, we have even some life without parole inmates within that population. Some of them are the types of inmates that wardens, where you have multiple institutions, will work to try to get them transferred from one institution to the other after a period of time, simply because his staff or her staff gets burned out on dealing with that particular inmate.

We have seen some dramatic turn arounds in the behavior of those inmates.

As far as pulling them into some of these programs, whether, you know, coercive treatment or not, I would simply agree with what Dr. Lipton has said.

I think the programs that we are operating, because many of them are the safest, the cleanest, the most orderly units within the prison system, that sometimes is the motivation for trying to get into them. And then as an end result, they also get the benefits of the treatment program that is there.

Mr. COUGHLIN. Mr. Aukerman.

Mr. AUKERMAN. I just wanted to comment in support of, in effect, making drug treatment an attractive option for offenders, for prisoners.

In Colorado, legislation has been passed to provide earned time for participation in drug treatment, as is available also for vocational rehabilitation and a variety of other things, subject to the approval of the parole board.

So that the individual offender, who is in need of treatment and is offered that opportunity, has another incentive to participate in that.

What we hear from participants in treatment is that it is often harder to do that than to do straight time, so that there has to be some other kind of motivation, either to improve oneself or that there will be some immediate gains, or you would have just the kind of situation that was described, where someone enters treatment with the goal of disrupting the process.

Mr. COUGHLIN. Mr. Chairman, thank you.

Mr. RANGEL. Mr. Guarini.

Mr. GUARINI. Thank you.

You are indeed a very dedicated group of people whose voice is just being heard on a subject that has long been neglected.

Of the people who are asking for treatment, are there many that are being refused because of lack of funds in our current system?

Ms. MORTEN. Absolutely.

Mr. GUARINI. And are there any funds on the State and local level for follow-up? The bill asks that there be post-treatment assistance, because you can get them to the point of their release, and if there is no follow-up, everything you have done has been lost.

Can you address yourselves as to what is being done on a State and local level as far as follow-up is concerned after they are discharged on parole?

Ms. MORTEN. There are a few programs in the District of Columbia that are offered, but they are offered on an outpatient basis through the board of parole and, I believe, the department of corrections through its halfway houses.

It is not the kind of intensive follow-up that you would need. After care is the most critical step of treatment.

We testified before the D.C. council a month or two ago, and asked for funding for our Oxford House-type model, where we would have six men living in a house, sharing expenses, going to their NA meetings. Really, no formal treatment would occur but we would provide some staff to monitor the participants' destinations, keep tab on their parole reporting employment, and that kind of thing. It costs about $150,000 to run a program for about 20 people.

There was just simply not enough money in the parole board budget for that item, and the council just said, "Look, just be glad that we are going to fund your prison-based program."

Mr. GUARINI. So you can't do the front end unless you have the back end of support. But where you have a shortage of funds in the prisons, do you prioritize as to the most violent criminals or the ones that are the most hard-core addicts? How do you handle your priorities then, if they come and ask and you don't have sufficient facilities for everyone?

Ms. MORTEN. We try to look at those who are due to come out the soonest and who have the most serious offenses. We feel that we can have the greatest impact on society in terms of the safety of society when they come out, especially since the parole system in this city is grossly understaffed, if they can have had the benefit of a prison-based program.

Therefore, we look to men who are within a couple of years of their parole eligibility. We have people who are in for murder, and for more serious offenses. But most of our population are there for the distribution and possession of crack, PCP, or heroin, and under the enhanced penalties have gotten some pretty stiff sentences.

Mr. GUARINI. Now you make great use of these people when they do come out. You use them for community service-based groups. You make use of the people and as a result there is a payback, I understand. This extended family that you speak of, are people that actually work and help in the process of developing a stronger base for treatment. Is that correct?

Ms. MORTEN. Exactly. Those seven men that are out now living in our Oxford House have been out about 60 days. Many of them have never been clean this long in their lives, and so it is real tough for them. And when they start coming in 10, 15 minutes late, our staff is there to monitor that, to help them to stay on track. When they stumble by coming in late, for example, instead of recommitting them to reincarceration, we take them right back to Lorton to see the family and explain their poor performance.

This is an intermediate—rather than sending them back to jail, which would happen if they were in a halfway house and violated the curfew. Instead we take them back for the weekend. We restrict their privileges and we say, we want you to come back into the family and explain to them why you can't come in at 11:30 on time. We also involve their biological family members in an effort to avoid relapse.

Mr. GUARINI. So working in your operation—the Unfoldment, is it?

Ms. MORTEN. Yes.

Mr. GUARINI. You then not only make use of their energies and talents, but you find that they are as effective as health care professionals in dealing with people? Or do you find they might even be more so as a result of their experience and desire to succeed?

Ms. MORTEN. Absolutely more so. Even in our youth program, we notice that a lot of the younger men, the younger boys in our program, listen to what these men have to say.

Mr. GUARINI. That is a wonderful story you are telling.

Ms. MORTEN. Yes.

Mr. GUARINI. We are very impressed up here.

Ms. MORTEN. Thank you. They listen to the men in our aftercare house more than sometimes they listen to the men who have never been in trouble who work for us.

Mr. GUARINI. Mr. Chairman, when we have that private meeting with the panel, which I think is a wonderful suggestion, perhaps we will have an opportunity of having one or two members of the family so that we might be able to also discuss with them their feelings and sentiments, and how they have been motivated. I think it would be very helpful to hear from them.

Mr. RANGEL. And our staff has visited the institution. We might want to consider taking a field trip.

Ms. MORTEN. That would be wonderful.

Mr. GUARINI. I do not think it is too far. It is about an hour from here, isn't it?

Ms. MORTEN. It is about a 30-minute drive.

Mr. GUARINI. So I think we could get there very easily.

Mr. RANGEL. You should realize that you got Mr. Guarini's attention when you said no doctors are involved. [Laughter.]

Mr. GUARINI. Just one last question. When it comes to alcohol, Dr. Lipton and those of you that are familiar, do we do more in the prison system for people with that type of substance abuse than we are talking about with hard drugs? Is it the same story, that they are also neglected? Or do they get cleaned out, dried up, rehabilitated, that we don't pay attention to the hard core drug addicts but we do attend to the medical needs of the alcoholics? Could you comment on that?

Dr. LIPTON. Well, I am not familiar with the rate of alcoholism specifically. Ninety-seven percent of all inmates come in with periods of excessive use of alcohol.

Mr. GUARINI. That is high.

Dr. LIPTON. Very high. Now the extent to which alcohol is specifically related to the crimes they commit, it is very hard to disassociate them, because for the most part they are involved with some level of alcohol use almost all the time.

Mr. GUARINI. But is it medically treated? If they are in prison, they have an alcoholic treatment program whereas you don't treat them if they have a drug problem?

Dr. LIPTON. Not really. I would defer to these two gentlemen on my side.

Mr. GUARINI. I am just wondering if there is a similarity or a parallel here, or if there is an attention to one and neglect to the other problem.

Mr. THIGPEN. I think there are some parallels. We certainly have those whose primary problem is alcoholism in the treatment programs that we are providing. And I don't think one is neglected at the expense of the other. We are trying to work jointly on both of them, because substance abuse, I think, involves both.

Most of the time we will see inmates who not only abused alcohol but other drugs or a combination. Very seldom do you see one who has just strictly dealt with alcohol.

Mr. GUARINI. But if I have a drug problem and report to the dispensary that I want help, I may not be able to get help. But if I have an alcoholic problem, I go to the dispensary in prison, is there a fairly good assurance that I can get help?

Mr. THIGPEN. No.

Mr. GUARINI. So neither is really getting the attention in our present system.

Mr. THIGPEN. There is a lack of attending to both.

Mr. GUARINI. That is sad. Thank you very much.

Mr. RANGEL. Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman. I would like to ask some very basic questions and maybe expose my ignorance here, but I learn from it.

I just have to get beyond the point of understanding why it is so easy to get drugs in prison. And if you would, just explain to me how that is so easy and why it is so possible.

I sometimes wish that we were actually interviewing inmates, rather than you all.

Ms. MORTEN. We have some here who could help you.

Mr. SHAYS. I really would enjoy that, because I think I could learn a lot from it. But maybe you all could take a stab at it.

Mr. THIGPEN. I think we found numerous ways that the drugs do get in. Certainly the inmates themselves, most prison systems will have some inmates who may have some outside contact because of job responsibilities outside the prison setting, and they will be on various work crews, that sort of thing. Sometimes, if you do not have the proper searching, they could come in that way.

Certainly visitors are a source of introduction of drugs. There is some feeling, I think, in some parts that staffs have played a role in that. We have not found in our system that that is a big part of the problem, but we do once in a while find a staff member who is supplying drugs to the inmate population.

And it can get very difficult, because we may have everything from body cavities on down used to bring the drugs into the system. They can be concealed in the incentive packages that inmates receive from the outside. Those have to be searched very carefully.

So any element that lends itself to being a means of introduction into the system probably has been used at some point.

Mr. SHAYS. Any additions?

Dr. LIPTON. Well, if you want to chronicle ingeniousness, you could find a tremendous number of examples of the way that drugs are smuggled into institutions. I mean, everything from making solutions of heroin and then dipping pages of books into it individually so the pages soak it up, dry the books, and then send the book to your friend in the institution, and then going through a reverse process of getting the drug out of the pages of the book.

In some States—Alabama is not one of them—but in some States that we visited, the guards were a primary source of distribution of drugs.

Mr. SHAYS. Let me ask you, I sometimes think welfare mothers are geniuses to be able to live on so little. What you are telling me is that inmates are pretty smart, too, in a reverse kind of way.

The other question I wanted to ask you was: My simple mind tells me that if someone is not able to get drugs for a few years and is in prison for a number of years without having drugs, that in a sense they have kicked the habit. I notice you are smiling. If you have not been taking drugs for 3 or 4 years, are you still having the same craving for it?

Ms. MORTEN. Oh, yes. I think I could respond to that, because we have an example. One of my staffers was telling me that when he was released—I believe he said when he was released from prison after 3 or 4 years, as soon as the bus took him across the 14th Street Bridge and he realized that he was now going to be in a position where he could get drugs as freely as he wanted, he started having almost flashbacks and he started tasting the drug.

In other words, the addiction is physical but it is also very, very emotional and psychological. That is why the treatment in the community to keep them stabilized for a period of time when they get back among those old friends and those familiar places and families is so important. Remember, a lot of these men go back to homes where mother or dad or wife or girl friend are still active

users. That is why it is so important to isolate them when they come back, so that they do not relapse.

Mr. SHAYS. I will just conclude by saying I am struck by the fact that, in a way, it seems to me that we have a golden opportunity. I mean, we literally have so many people who are faced with drug addiction right there, you know, somehow ready to be treated. Well, I say ready to be treated. As I make that comment, obviously if they are not ready to be, then we are going to have a hard time helping them.

But I really feel, Mr. Chairman, that if we were able to spend a little more time on this issue, we might make a major contribution to society.

Mr. RANGEL. Amen.

Mr. SHAYS. You wanted to make a comment?

Mr. AUKERMAN. Just to reinforce that, that being separated from the drug or being incarcerated, so that you are not using the drug, whether the drug is alcohol or illicit drugs, stops the behavior. What it does not do is provide the opportunities for the individual to make the changes that they need to discontinue the addictive lifestyle. So that once the opportunity to take drugs presents itself again, all you have done is stopped things for a period of time.

Mr. SHAYS. Thank you.

Mr. RANGEL. Mr. Shays, I agree with your observations and I am very optimistic. We have the distinguished Dr. Beny Primm here, as well as our Director of the Federal Bureau of Prisons, Mr. Quinlan. I am more than confident that after they have heard this testimony and felt and heard the enthusiasm of this panel—and knowing that they can reach out to formulate a national policy, as opposed to just appropriating and authorizing funds—they will be able to even excel the States and attribute their success to Dr. Bennett by having everyone know that our Federal Government wants to be of assistance to local and State government. This has been a very exciting panel.

Congresswoman Lowey.

Mrs. LOWEY. Thank you. I, too, would like to join my colleagues in expressing my appreciation to all of you for your testimony. It gives us hope.

Let me say, in visiting prisons in my district, Ms. Morten's testimony really rang true what I heard over and over again as I sat with 50, 60 or more inmates several times. We are really dependent, not independent, you are giving us a bed, you are giving us food, you are not teaching us to take hold of our lives. And it seems to me this is what your program does so well, so magnificently.

What I would like to learn, and if you addressed this, I apologize if I missed it, was the cost. Could you perhaps tell us the cost per person for an inmate in your program versus the cost per person for an inmate that is not in the program? Let's talk about the cost in prison, and then of cost of aftercare and followup, and job placement.

It seems to me it is certainly very cost effective for us, considering the whole person and what happens after and the cost to society. So perhaps you could expand upon what it would cost us to keep a person in this program.

Ms. MORTEN. OK. It costs in the District of Columbia, at Lorton, about $20,000 to house a prisoner. That does not, of course, include the cost of building the cell and the court costs, and the parole board cost. Just the cost of housing a man for a year, feeding him and sheltering him, is about $20,000 a year.

Our program is approximately $5,000 a year. So that would be a total of $25,000 a year. But assuming that person does not come back into prison, you have saved that additional $20,000 a year. And the aftercare is significantly less than that, approximately $3,000 a year per aftercare participant.

Mrs. LOWEY. That is the point I wanted to emphasize. It is certainly cost effective and it makes sense for us to invest in those programs up front.

Second, I have found in my work with Renaissance and Phoenix House, and other programs in my district, that it is extremely difficult to get trained people in this field. And I have advocated, and I had legislation in the last session, a loan forgiveness program. You get paid more in the A&P than you do as a drug counselor, and this goes for other fields, too. Home health care attendants, child care workers, et cetera. You are not alone.

What is your experience in getting people to work in this field, to work in the prison?

Ms. MORTEN. Well, we believe in paying good wages. I believe we pay probably the highest wages for entry-level counselors in this area, both in community based and prison based programs. And we do that to attract and retain good people.

For example, most of my counselors were making approximately $14,000 to $16,000 a year at community-based organizations. We started them out at $20,000, and the job pays up to $25,000 a year. Our assistant director position goes up to $40,000 a year.

While it sounds like a lot of money, these people are extremely dedicated. They put in 10, 12 hours a day because of their commitment. They want to give something back and help someone. Therefore, they won't tell me at 5 o'clock, "Look, I have got to go home, you know, my day is over and you are not paying any overtime." We don't pay overtime and yet our staff works until the job is done.

So we use recovering people and they are very often very happy to make that kind of money, because, as you said, the only other recourse is A&P or something like that.

Mrs. LOWEY. What is the average length of time a person stays in your jobs?

Ms. MORTEN. We have only been around since March 1, 1990, about 15 months, and we have only lost one of our full time counselors. So we have had a pretty good retention rate.

Mrs. LOWEY. Thank you very much.

I do hope that we have the opportunity, Mr. Chairman, to continue this discussion.

I am particularly interested in the job placement aspect, too, because the other problem that was presented to me by the inmates over and over again is, their time is up, they are given a small amount of money, go forth, young man, into the world. They do not have a job. They go right back to the community. An hour later

someone says, hey, man, and they are right back in the prison again.

So that I am very interested in that component. I don't know if we have time to talk about the job placement aspect.

Ms. MORTEN. Could I just say one quick thing on that? I think that is absolutely, absolutely essential. What we came up with is a certified addictions counselor training program for the men in their second year of the program. Some of them are not going home after the first 48 weeks because of their sentence structure. So we allow them to stay in Unfoldment another year. We offer a 32-week course that trains them to become certified addiction counselors and pay their fees to take the exam. If they pass the exam, when they come out they are certified counselors as recovering people. If this bill is passed, there are plenty of jobs waiting for them to go back and help others.

Dr. LIPTON. If I may, Mr. Chairman, just to add a footnote to that. The figures of the Stay'n Out Program, when asked why they failed—and indeed they stayed out longer, 18 months on the average, whereas in contrast to 10 months for the controls—almost always the answer was vocationally related. That is, they did not have an opportunity to work.

Mrs. LOWEY. Thank you very much.

Mr. RANGEL. We are going to have to break now. I would not want to hold this panel up, but we will not be back for 15 minutes, because we have two votes on the floor. And I do not know whether anyone else would want to question this panel.

If no one else does, I just want to thank you, rather than hold you up, and also to congratulate Mr. Morten for being able to raise such an outstanding daughter and attorney. She certainly has impressed us.

Mrs. Lowey, if we get the idea that job training might prevent people from returning to jail, who knows, the Administration might look to education as a source to keep people out of jail in the first place.

Mrs. LOWEY. That sounds like a great idea.

Mr. RANGEL. I know, but we don't want to get carried away with these concepts.

But let me thank you all.

The committee will stand in recess until 4:10.

[Recess.]

Mr. RANGEL. We will resume the hearing. Let me thank the panel for their patience. We have had waiting all afternoon Director Quinlan of the Federal Bureau of Prisons and, of course, a dear friend of the committee, Dr. Beny Primm, who directs the Office of Treatment Improvement.

In consideration of time, your statements will be entered into the record, and you may proceed, starting with Mr. Quinlan. And I hope both of you would take into consideration the testimony we already received this morning.

STATEMENTS OF J. MICHAEL QUINLAN, DIRECTOR, FEDERAL BUREAU OF PRISONS, ACCOMPANIED BY DR. DON MURRAY, NATIONAL PROGRAM COORDINATOR FOR DRUG TREATMENT, AND BENY PRIMM, DIRECTOR, OFFICE OF TREATMENT IMPROVEMENT, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF J. MICHAEL QUINLAN

Mr. QUINLAN. Thank you, Mr. Chairman and members of the subcommittee.

First of all, I would like to introduce one of the employees of the Bureau of Prisons, who is very vitally involved in the whole issue of drug treatment, and who is to my left, Dr. Don Murray, our national program coordinator for drug treatment. I have him along as a technical advisor on any questions that the committee might have.

Mr. RANGEL. Welcome, Dr. Murray. Is that M.D. or Ph.D.?

Dr. MURRAY. An ED.D.

Mr. RANGEL. An ED.D., what is that?

Dr. MURRAY. I am a licensed psychologist and I have a degree in clinical psychology at the master's level, and a doctorate in education, specializing in learning development at the doctorate level.

Mr. RANGEL. Thank you, Doctor.

Dr. MURRAY. Thank you.

Mr. RANGEL. Mr. Quinlan.

Mr. QUINLAN. Thank you, Mr. Chairman.

As you indicated, the remarks will be very brief. I just wanted to touch upon a couple of key points, as we see it, in the whole area of drug treatment.

First of all, our population is increasing rapidly. We now have 62,000 prisoners in the Federal prison system in 67 different locations. Approximately 55 percent of those, Mr. Chairman, are offenders serving terms for drug offenses.

One-half of those who are serving terms for drug offenses are categorized as having moderate to serious addiction problems. A total of 47 percent of our population overall, whether drug offenders or not, are in that category of having a moderate to serious addiction problem.

Our program in drug treatment is divided into a couple of areas. I want to just mention them briefly.

First, education. Every prisoner who comes into our institution with any indication of addiction or substance abuse problems, is mandatorily put into an education program that would teach them some of the whys and hows of addiction and drug and substance abuse. Preferred work assignments and other activities in the institution, privileges, and eligibility for release from the institution are limited if you do not participate in that program.

We also have drug counseling programs throughout our institutions for those who want to take advantage of any kind of counseling, regardless of the level of their status as a substance abuser.

The real standout programs in the Bureau of Prisons, I think, are in the area of comprehensive treatment and the pilot programs that we now have at 8 of our 67 institutions. Hopefully, by the end of this fiscal year, we will have these programs at 13 of our institu-

tions. By the end of the next fiscal year, if we are able to achieve the budgetary level that we have requested, and that the President has requested, we would have these programs in 31 of our 67 institutions.

These programs are, we believe, very, very beneficial to those prisoners who have these moderate to serious drug abuse problems.

The comprehensive program is a 500-hour program. There are 240 hours of group and individual counseling, 100 hours of wellness lifestyle training, and 40 hours of discussion on transitional living issues. During this comprehensive program the inmate also participates in institutional work and school assignments.

One of the main things we try to teach is how to deal with your problem and how to prevent relapse when you return to that community, which was generally the environment that got you hooked on this whole substance abuse problem in the first place.

Each of the comprehensive programs has about 100 to 125 inmate participants.

Our three pilot programs, which are what we consider state of the art, have 1,000 hours of treatment available to the inmates. It is a 12-month program and heavily, again, involved with relapse prevention and training of that nature.

Both of the major programs in the Bureau are tied in heavily with research. We were very fortunate to receive a grant from the National Institute of Drug Abuse of $3 million for the whole drug abuse treatment research initiative, and we are working very hard to make sure that we learn this time around everything we can possibly learn from our initiatives in the area of drug treatment.

All of our residential drug treatment programs, I should add, Mr. Chairman, have a heavy emphasis on transitional reintegration drug treatment. After the treatment in the institution, you would then follow up with 6 months of intensive drug treatment in the community, in the environment where you would most likely fall prey to returning to the use of drugs or alcohol. With that heavy emphasis on treatment and with the follow-up on transitional services, we are optimistic that we can make a difference in the area of drug treatment.

I would like to just make one closing comment. We do a great deal of testing of inmates in our Federal institutions to ensure against drug utilization in prison.

Some have the perception that drug use is highly prevalent in institutions. I am happy to report that we have seen a decline every year since 1985 in Federal institutions in drug use, culminating in 1990 with 71,000 tests and 1.9 percent of those tests being positive, or about 1,400 prisoners overall over the course of a full year being found guilty of having used some kind of a drug.

Despite the fact that most prisoners have no access to drugs, it does remain a serious problem, as was pointed out by the prior panel, and you can never, despite the long lapse of time when one might have the opportunity to use drugs, think that the addiction is gone, because it won't be unless you treat it, from all I understand about the problem.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Quinlan appears on p. 142.]

Mr. RANGEL. Thank you, Director.

Now we hear from Dr. Primm. Again I thank both of you for your patience with the hearing.

STATEMENT OF BENY PRIMM

Dr. PRIMM. First of all, Mr. Chairman, I would like to tell you that the commitment that I made to this committee last year, when I was here, has been fulfilled by the Office of Treatment Improvement in the Alcohol, Drug Abuse and Mental Health Administration.

That is, to have an initiative in the prison system to do drug treatment within the prison system. And I am just happy to announce that I think it has been fulfilled to the best of my abilities, using available funds.

There is certainly room to expand on the infrastructure that is being developed. But the programs are out there, the programs are operating.

Two of the individuals testified here on the previous panel—Commissioner Thigpen has a grant of over $800,000 from the Office for Treatment Improvement.

And, of course, Dr. Lipton has a grant from our office to continue his research and evaluation of the efficacy of what is going on in the prison system.

So I am very happy about that, and many other people within the country are also.

I am pleased to testify here today regarding this critical component of our efforts in the war against drugs.

As you all know, this has been part of the President's national drug control strategy. And, of course, my office is the one that pretty much carries out that strategy.

It is fitting that we target our efforts in these areas in our Nation for three specific reasons, I feel.

And that is, that the need is very great for the kind of efforts that we want to do in the criminal justice system and in the prisons, and in that substance abuse treatment does work.

And I am a big proponent of that, as you have always known, that I feel it works and it would work better if it is comprehensive, and certainly that there is a growing willingness now within both of the communities of drug treatment and within the criminal justice system and prisons that we want to work together to link these two systems.

And nothing is more indicative of that than a recent conference that was sponsored by my office out in Albuquerque, NM, where we brought together people from the criminal justice system and people from the substance abuse treatment arena.

As a matter of fact, here is a copy of OTI's model for criminal justice addiction treatment planning that was distributed at the conference, a model that I will leave with you when I leave here today, and a conference manual for members of the committee to peruse as they see fit, to see the kind of efforts that are being put forth by the Alcohol, Drug Abuse and Mental Health Administration, and particularly by my office, the Office for Treatment Improvement.

There are other things going on at ADAMHA that I think are really important for you to know.

The National Institute of Drug Abuse has hosted a technical review of treatment programs in the criminal justice system settings.

The Office for Substance Abuse Prevention, Dr. Elaine Murphy-Johnson's office, has funded treatment demonstration programs for high risk youth which have as a focus treatment for juveniles involved with the criminal justice system.

I think that is one of the very fine ADAMHA initiatives.

My office, of course, has obligated in 1991 $16 million for a series of programs that address the needs of the criminal justice population, including both establishment and continuation of jail-based and prison-based treatment improvement and habilitation programs, diversions to treatment programs that allow arrestees charged with misdemeanors to be directed to treatment under court supervision, programs which establish mandatory treatment as a condition of parole for persons who have already served time in prison, and certainly treatment improvement demonstration programs within the juvenile justice system.

All of these programs are for three year grants. Initial awards were made in September, 1990. We expect to make additional awards in September, 1991.

I also want to note to you, Mr. Chairman, that just starting treatment programs within the prison system, I don't think, is enough. I think a lot of these youngsters and adults come from the communities that you and I know so very well are—many of them are blighted, where unemployment is high. These individuals have many other problems, that rehabilitating or doing drug treatment is not what is necessary. A lot of other things are necessary.

I think habilitation is necessary. And in doing so, with these underprivileged individuals, we need a much broader, comprehensive drug treatment service within the prison system, much more than we are just talking about here today, in order to have people vocationally rehabilitated. There needs to be some family rehabilitation, unquestionably, some emphasis on their after care, even inducements that were talked about maybe today to induce people to be more embracing of drug treatment within the prison setting and outside of the prison setting.

I had a number of things here that I had to say, and I would rather, I guess, at this juncture, because of the time constraints that we have, tell you that what I would like to see is a very comprehensive approach in the prison system, where people who are HIV infected—and you know anywhere from 2 to 6 percent of the people who are in prisons are infected with the human immunodeficiency virus.

In our State, Mr. Chairman, in New York, 17 percent of our prison population is infected with HIV. And AIDS, of course, is rampant. You heard Ms. Morten talk about people coming out of that system and maybe infecting their significant others, as well as sharing needles and drugs in the prison system.

I think any use of drugs, not just injecting drugs, can of course lead to the possibility of infection with human immunodeficiency

virus and, of course, rampant epidemiological problems within our community secondary to this population.

So we need to also focus on primary medical care and treatment of HIV infection prophylactically within the prison system, following them when they come out and including their families. But if we don't do that, I think we will be making a terrible mistake.

The Commission on AIDS now has recommended that there be treatment and education for not only prisoners but people who work throughout the criminal justice system about this particular problem.

I think the potential for both the decreased drug use and reduced crime that this will bring about certainly will benefit our Nation greatly. And I think it is a must that Federal and State and local areas must work together, linking whatever support systems that we have, so that the infrastructure can better accommodate these individuals that find themselves in that situation.

I don't think the existing network of human resources and services are up to par, what they should be, not in my own town nor in the country. There has not been enough concentration on that. And I am pushing for that everywhere I go, that these linkages take place so that people who need, for example, subsistence can get it when they come out of prison.

People who need other vocational training, I am encouraging people within communities to develop good vocational training. I am encouraging people to open up group homes for recovering substance abusers so that these people have a decent place to live and do not have to return to a family that may be an enabling family.

With those kinds of remarks, somewhat fragmented and not in keeping with the formal presentation I had, I would like to close now and be willing to take any questions from the panel, Mr. Chairman.

[The prepared statement of Dr. Primm appears on p. 148.]

Mr. RANGEL. Dr. Primm, that is a pretty powerful statement that you presented to us. And I certainly agree with everything that you have said, that you just can't look at a piece of a person's life and think that you can cure that with detox and a Band-Aid, that you really have to habilitate and have a person not only have self esteem but to be able to have some reason to maintain it, to have some type of skills, to get out there and be able to be competitive in some area.

And I would assume that if it makes sense for someone who has violated the law and been convicted and he is in prison, and you are trying to keep him or her from coming back, that it would make just as much sense for someone who hasn't been arrested and who is not in prison, and that you are trying to prevent them from falling prey or victim to drug addiction and criminal behavior.

Would that not make sense?

Dr. PRIMM. Absolutely. I think the bio-psychosocial issues that concern these individuals may go far beyond what they have done criminally.

So we are going to have to concentrate on those issues, too, to make people then appreciate the system which they happen to be in that may be even punitive, but it can be a little bit user friendly.

If they are in the system, it does not have to be so totally punitive that they are turned off and they become a total enemy of society. We can make that system a lot more friendly by concentrating on some of those socioeconomic ills that are out there and some of the pathology that we see in individuals that I think our socioeconomic ills breed.

Mr. RANGEL. I guess what all of you would be saying is that not only is it the right thing to do, but in terms of cost effectiveness, that these people will be less likely to return to a very, very expensive system and also the expense of putting them back in the system.

Now having said all of that, Dr. Primm, and complimenting you for fulfilling your commitment and focusing Federal attention on this problem, and in the climate in which we live politically today, how would you recommend this committee move forward to do the comprehensive type of thing that you are suggesting?

Dr. PRIMM. We are already doing that, Mr. Chairman. All of our treatment programs where we have dollars, our demonstration grant programs, are comprehensive treatment programs.

Mr. RANGEL. Let me interrupt, because what you are doing is pilot and demonstration. The problem that we have, as Members of Congress, is that, you know, where we talk about the criminal justice system, we are talking about the Federal Government. We go back home, people do not distinguish between the Federal Bureau of Prisons and the Federal treatment program. They just wonder, what are you doing, why are all of these people just going in and out of jail and on and off again with drugs.

So I can appreciate that for the first time we do have locked into place research where we will be able to evaluate exactly what systems work better than others. But you really don't have to be a psychiatrist to know that we haven't been doing these things adequately in the past. And whether it is community based or whether it is institutional, we can really have a better control over this person's life if we pay more attention to it.

Now having said that, this is the worst constituency in the world to lobby for. And so we have to lobby for the police in saying, hey, we are making your job easier. We have to lobby for the judges and say, hey, we are trying to keep them out of court. We have to lobby for you, to keep them out of the prison system, and then lobby for the mayors because it reduced the budget, and the Governors.

What role can the Federal Government play in setting the tone for mayors—not the tone—creating a climate where politicians would feel that they are not do-gooders, they are not being kind to criminals, but they really are doing budget restraint types of things that make sense? Because to have this knowledge and not to be able to do anything with it is frustrating.

Dr. PRIMM. I think when something is proven to be efficacious in our pilot projects, Mr. Chairman, these things can be picked up and expanded upon by using the block grants, both ADMS [Alcohol, Drug Abuse and Mental Health Services] block grants and the BJA [Bureau of Justice Assistance] block grants to expand upon these programs that we know that are efficacious.

I would be unwilling to try things that notoriously have failed. I think a lot of those things are still going on out there.

I think that some of the new methods that we know that are effective should be expanded to make things more user friendly within the prison system, and to make people want to embrace drug treatment. People don't want to embrace drug treatment, either outside of the prison system or inside the prison system, as much as I would like to see it happen.

There would not be thousands and thousands of people who need drug treatment who don't come into drug treatment, even though there are spaces for them to come into drug treatment, if that were not so.

So we are trying to make and introduce to the States and to cities that drug treatment can be friendly, drug treatment can be expanded to include the family members.

We know that when treatment works, unemployment goes down. We know that when treatment works, HIV infection goes down, criminal behavior goes down. When we have comprehensive one-stop shopping, bringing all those important programs out there that——

Mr. RANGEL. I don't want it introduced to the States. I want it mandated. I don't want the Secretary of Education circulating model programs to schools.

If you know it works and you are in charge of a national effort to rehabilitate, and Mr. Quinlan is the Director of the Federal Prison System and he has seen how this works, and the President has a war against drugs for which there are limited Federal dollars to do all the things we want to do, then why do we have this block grant where the money is turned over to the Governors who many times have to decide politically how the funds are to be spent? To me, we in Congress are not fulfilling our Federal legislative responsibility by just appropriating more and more money and fighting with the President, who is asking for more money for drug treatment. And that is what we do.

If all of you experts—and we are not experts—have identified one way that bucks really work to reduce social problems, criminal problems, budgetary problems, and then you have the Federal backup with research and pilot projects and demonstration projects, so that nobody can dispute that what you are saying is not liberal democratic political garbage, it is stuff that really works, then I would want some kind of way where we say, you don't understand the program, you don't get the dollars.

Dr. PRIMM. Let me answer that by saying that the block grant, as you know, is in my Office for Treatment Improvement. We have no way at this time, Mr. Chairman, to track those dollars. We don't have State treatment plans. We do have some voluntary commitment to State treatment plans.

We have introduced the State Systems Development Program. We have about 27 States that have voluntarily participated in that plan, so that we can work with States to introduce some of these programs that you are talking about.

There are two—the Code of Federal Regulations, 45 CFR, section 96, does not allow me to go into the States and mandate them to do anything with the alcohol and drug abuse block grant.

Mr. RANGEL. I know that. I am not pointing to you. I am saying, as Federal legislators. But I have to find out, before we get in-

volved in this mandating mode, that we know what we are talking about.

Mr. Coughlin.

Mr. COUGHLIN. Thank you, Mr. Chairman. First I would like to get the figures straight in my head.

According to your testimony, you now have about 60,000 people in the Federal Prison System. Is that right?

Mr. QUINLAN. Actually, Mr. Coughlin, it is 62,000 today.

Mr. COUGHLIN. And about 55 percent are drug offenders?

Mr. QUINLAN. About 55 percent drug offenders, that is correct.

Mr. COUGHLIN. How many would be in the State and local prison systems?

Mr. QUINLAN. Serving sentences, about 720,000 prisoners, according to the most recent Bureau of Justice statistics figures.

Mr. COUGHLIN. So you have got something less than 10 percent of the total.

Mr. QUINLAN. About 8 percent, Mr. Coughlin.

Mr. COUGHLIN. And if I recall properly, in one discussion we had with regard to boot camps or alternative methods of incarceration that might include drug treatment, you indicated that those between the ages of 18 to 24 would be eligible.

Mr. QUINLAN. Actually, our boot camp goes up to 35.

Mr. COUGHLIN. Eighteen to 35, first time offender, nonviolent offense. How many would qualify in your system?

Mr. QUINLAN. Actually, we have the program ongoing now. We would probably have less than 1,000 who would qualify under that criteria.

Mr. COUGHLIN. Less than 1,000 out of your 62,000 would qualify?

Mr. QUINLAN. Yes, sir.

Mr. COUGHLIN. So that the majority of your folks are pretty tough.

Mr. QUINLAN. Well, most of them are serving longer sentences than the statutory limitation. That is another criteria I forgot to enumerate. And that is a 30-month sentence or less, a nonviolent first offense, under the age of 35, medically qualified. There are not that many of those folks in our institutions. Our average prisoner is 37 years old, serving a fourth felony conviction, and has a history of fairly severe criminal behavior.

Mr. COUGHLIN. Do you feel you have a treatment or rehabilitation program that does something for those people?

Mr. QUINLAN. We are very excited about the results of our intensive confinement or boot camp program for the group that has been in the program now since about January 25, 1991. We are extremely excited about that.

A large percentage of them are serving terms for drug offenses, although there were some that are nonsubstance abusers. But our other institutions, the other 66 institutions, also provide, as I mentioned, these eight comprehensive drug treatment programs. And all of them offer mandatory education and drug counseling.

So the intensive confinement or boot camp initiative is just one aspect of our multifaceted approach.

Mr. COUGHLIN. Now you projected that the Federal prison population will go from 62,000 to 98,000 by 1995, with 69 or 70 percent being drug offenders. Is that correct?

Mr. QUINLAN. That is correct.

Mr. COUGHLIN. That doesn't show very much success, does it?

Mr. QUINLAN. Well, certainly the number of prosecutions for drug offenses relates to the fact that Congress has enacted new laws in the drug area. For example, the 1988 antidrug abuse legislation resulted in what we expected, about 12,000 new prisoners in our institutions. Other legislation which has brought about either new Federal jurisdiction or mandatory minimum sentences has resulted in increased prosecutions at the Federal level and, as a result, increased incarcerations. So it is not just a case of a failure to treat people as much as it is a widening of the Federal initiatives that are trying to cope with the drug problem.

Mr. COUGHLIN. One more question. I know we are running out of time here.

What advice do you have as a result of your experience to the States and local governments?

Mr. QUINLAN. Well, I think that as the previous panel indicated, there are many approaches to dealing with the problem. My very strong advice is that you really should be doing something to deal with this problem, that these people who are coming into our institutions at an ever-increasing rate are in need of some help.

Now whether it is going to be a cure all—I don't think there is a panacea, Mr. Coughlin. But I do think that if we can provide the motivation and the opportunity for good treatment programs, there can very definitely be a positive impact and hopefully a reduction in future drug use and future crime.

Mr. COUGHLIN. Mr. Chairman, let me yield because of our time.

Mr. RANGEL. Thank you.

Mr. Guarini.

Mr. GUARINI. Thank you.

Mr. Rangel and I have a bill, H.R. 730, and I understand that you may have taken a look at it.

Mr. QUINLAN. Yes, sir.

Mr. GUARINI. Are there any recommendations or suggestions that you can give us to perfect the bill further?

Mr. QUINLAN. Well, we appreciate very much, Mr. Guarini, the opportunity to work with your staff, and we are hopeful that the Department is supportive of the legislation if there could be a couple of modifications made.

I don't want to suggest that I can speak for the Department of Justice on this, but a couple of the issues that we are concerned about are the provisions regarding early release, provisions with regard to voluntary drug testing, and the mandatory use of employee positions rather than contract positions.

I think there is really, as your staff and yourself have indicated in correspondence with me, great interest in communicating and dialoging on these issues, and working out a reasonable——

Mr. GUARINI. We appreciate your input. And perhaps it can save time, if you haven't already given the information to my staff, perhaps you might be able to supply in writing some of the recommendations and suggestions. We do appreciate your input.

Mr. QUINLAN. Absolutely. In fact, we have submitted our comments to the Department and I hope that a response can be given to you and your staff very shortly.

Mr. GUARINI. Thank you.

Dr. Primm, do you have anything to add to that?

Dr. PRIMM. Certainly. I would think that my greatest concern would be how will the States be able to fund these particular programs after 4 years, with the declining Federal contribution to these programs. The situation that the States find themselves in now is so, so, so terrible that I am concerned about how they will be able to provide ongoing funding for these programs.

Mr. GUARINI. You have $738 million in your budget, as I understand it, in OTI. Is there a way that you can set aside certain sums of money for the State and local prisons, so that we can ameliorate the situation that you are speaking of? How could we help these State and local prisons?

Dr. PRIMM. ADM block grant dollars are some $1.2 billion.

Mr. GUARINI. From the block grants, can you specifically give money for the prisons, drug treatment in prisons? Or do you just give block grants and the States decide how they want to use it?

Dr. PRIMM. Other than the statutorily mandated set-aside, the States decide how they will allocate funds. Perhaps the Bureau of Justice Assistance block grant is another ball game. They might have some moneys that they could dedicate to that arena.

Mr. GUARINI. But should the Federal Government lay down some guidelines to the State and local governments in order to make sure that we have a national strategy?

It seems that of the 710,000 people that we have in our prison system, there are 61,000, I understand, in the Federal prisons. State prisons have 10 times as many. And you probably have a looser application within the State and local systems.

So I was wondering if there is a way that we could develop a national strategy where the Federal Government could have input and guidelines, to make sure that we do have some uniformity and some effective programs in our State and local prisons.

Dr. PRIMM. We would certainly suggest strongly to States that something that has been efficacious should certainly be extended. Beyond that, we don't have the right nor the legislative mandate to go in there and do that. That is why we are pushing for a statewide substance abuse prevention and treatment plan and a State systems development program in administering the Alcohol, Drug Abuse and Mental Health Service block grants.

Mr. GUARINI. Well, HHS and the Department of Justice are two different departments. Where should the principal responsibility be regarding the AIDS in prisons and the drugs in prisons that we are trying to address right now?

Dr. PRIMM. I think it should be somewhat joint, and that is what you see is happening now.

Mr. GUARINI. Well, maybe that is the problem, because then you are not pinpointing the responsibility. You are saying two different departments, it is overlapping.

Should there be a principal responsibility, either HHS or the Department of Justice, over trying to address these people-oriented programs?

Dr. PRIMM. Well, I think that the prison system comes under one jurisdiction and health and human services is another jurisdiction.

Mr. GUARINI. Right.

Mr. RANGEL. Would the gentleman yield?

Mr. GUARINI. Yes.

Mr. RANGEL. Doctor, would you want your Department authorized to mandate the type of programs that you have found to be effective, to mandate them in these block grants? Would you want that type of authorization?

If you know they worked and you have had these pilot projects, and your research, and these people don't return to jail, and they have got self-esteem and training, and then you thought you got a lot of bang out of your buck. Would you want, as the director of your program, to have legislation which would mandate that if you want this money, you have got to show what you are doing in these prison programs?

Dr. PRIMM. I would rather, Mr. Chairman, reserve my comments on that issue at this time. I think that it needs a lot of thought before any commitment could be made one way or the other.

Mr. GUARINI. Would you give us the benefit of your thinking after you have had an opportunity of culling out the pros and cons, without putting you on the spot, Dr. Primm? Because we really need that kind of input. It is very important that we have the benefit of your experience. That is what the essence of these hearings are.

Mr. RANGEL. The problem is that we would be putting everyone on the spot. If you mandate, that means accountability. That means that you have to be involved to see whether or not they are fulfilling the mandate. That means you have Federal fingerprints on State programs. And that is exactly what the administration doesn't want.

Mr. GUARINI. But maybe that is what we need. Maybe that is the problem.

Mr. RANGEL. No. But that is why you cannot ask the question without putting people on the spot.

The whole idea is block grants, do what you have to do. And unfortunately, Dr. Primm and Mr. Quinlan, Governors and mayors have to do what they have to do, and some of them, they don't have to go for these attractive type programs because they don't really get any votes for doing the right thing. Pregnant mothers, mother's aid, those types of things are worthwhile. But your programs, unless they can have some Federal direction, in my opinion, it is going to be a long haul for them to be done on a volunteer basis.

Mr. GUARINI. Let me ask you lastly, Dr. Primm and Mr. Quinlan, do we have more problems in the Federal prisons that have aftercare carried through when they leave the prison?

With the State and local prisons, you have more community-based organizations that are set in place by the governments themselves. And of course you do have some nonprofits.

But is there a problem in carrying through the aftertreatment and the rehabilitation and the job placement, where you are talking about Federal prisons as opposed to State and local prisons?

Mr. QUINLAN. If I could answer that, sir. The Bureau of Prisons utilizes these contract public and private facilities, some voluntary and some otherwise. And we have been satisfied thus far with the ability to use these facilities.

Even though they are not federally operated, they are providing some excellent services. So it is not a problem for us.

Mr. GUARINI. And lastly, is there a base of experience from Europe that we can draw some lessons from? Do we learn from the other industrialized nations of the world? Are they doing more than we are in attending to this problem in our prison system?

Dr. PRIMM. Let me say this. We are dealing in other countries with populations that are pretty much homogeneous. The cultures are different.

I think that we can certainly look at those situations and learn from them. But they may not be directly applicable to our problems here in this country because of the heterogeneous relations that we have and the different cultural kinds of basic problems that are in this country.

Mr. GUARINI. We are a mix of everybody's culture, it seems.

Dr. PRIMM. Well, that is true. And, of course, that is quite different. I think to take a page out of somebody else's book, and that other book was written for a specific problem, you can't take that page out and make it applicable to this problem.

Mr. GUARINI. Thank you.

Thank you, Mr. Chairman.

Mr. RANGEL. Thank you.

We have to run to vote. But Dr. Primm, thank you for your generous offer to work with us, and Mr. Quinlan, to sit in with this group.

I have already talked with Congressman Schumer, and he is very anxious to see what we can do. And I know mandate is a rough term, but if we can do nationally to get the word out there, maybe the people will force the mandate, as opposed to the Federal Government.

But we have got to get the word out there in a way that it doesn't look like it is coddling, and that is the problem.

Thank you very much.

[Whereupon, at 5:06 p.m., the Select Committee was adjourned.]

PREPARED STATEMENTS

OPENING STATEMENT
RANKING MINORITY MEMBER LAWRENCE COUGHLIN
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL
HEARING ON DRUG TREATMENT IN THE CRIMINAL JUSTICE SYSTEM
MAY 14, 1991

I WOULD LIKE TO JOIN CHAIRMAN RANGEL IN WELCOMING TODAY'S WITNESSES. I LOOK FORWARD TO A FRANK DISCUSSION ON THE SIGNIFICANT RELATIONSHIP BETWEEN DRUG TREATMENT AND THE CRIMINAL JUSTICE SYSTEM.

THE NUMBER OF OFFENDERS ENTERING THE CRIMINAL JUSTICE SYSTEM WHO ARE TESTING POSITIVE FOR DRUG USE IS OVERWHELMING. INSOFAR AS DRUG USE IS CLOSELY CONNECTED TO THE CRIME THAT RAVAGES OUR NATION, IT IS IMPERATIVE THAT WE FIND WAYS TO ADDRESS THIS PROBLEM. THE CRIMINAL JUSTICE SYSTEM OFFERS A UNIQUE OPPORTUNITY TO PROVIDE TREATMENT FOR SOME SEGMENTS OF THE INCARCERATED POPULATION.

I AM OPTIMISTIC THAT TREATMENT CAN WORK WITHIN THE CRIMINAL JUSTICE SYSTEM AND AM ANXIOUS TO HEAR YOUR THOUGHTS TODAY AS TO HOW WE CAN BEST PROVIDE COMPREHENSIVE, EFFECTIVE TREATMENT FOR THOSE INMATES WHO CAN BENEFIT FROM IT.

UNFORTUNATELY, IT WOULD SEEM THAT WE ARE TO SOME EXTENT HAMPERED BY THE LACK OF SOLID RESEARCH DATA ON WHAT IS EFFECTIVE IN THE TREATMENT OF DRUG ADDICTED INMATES. FOR THIS REASON, I STRESS THE NEED FOR CAUTION AS WE DEVOTE INCREASED LEVELS OF FUNDING TO THIS EFFORT. THERE ARE MANY PEOPLE IN THE NON-CRIMINAL JUSTICE POPULATION WHO ARE IN NEED OF TREATMENT, THEREFORE, WE SHOULD MAKE CERTAIN THAT TREATMENT WORKS IN THE CRIMINAL JUSTICE SETTING BEFORE WE DEDICATE LARGE AMOUNTS OF SCARCE RESOURCES TO ANY MARKED EXPANSION OF OUR EFFORTS IN THIS AREA.

THE ADMINISTRATION HAS PROPOSED--AND CONGRESS HAS FAILED TO PASS--LEGISLATION TO INCREASE THE ACCOUNTABILITY OF TREATMENT PROGRAMS THROUGH STATEWIDE TREATMENT PLANS. THROUGH THIS LEGISLATION, STATES WOULD BE REQUIRED TO EXAMINE THE NEED FOR TREATMENT WITHIN THE CRIMINAL JUSTICE SYSTEM AND TO SHOW HOW THE FUNDS ARE GOING TO MEET THOSE NEEDS. IN MY VIEW, THIS IS TIMELY, IMPORTANT LEGISLATION UPON WHICH CONGRESS SHOULD ACT IMMEDIATELY.

I WOULD ALSO LIKE TO STRESS THE NEED FOR WIDESPREAD DRUG TESTING THROUGHOUT THE STATE CRIMINAL JUSTICE SYSTEM IF WE ARE REALLY GOING TO GET A HANDLE ON THE EXTENT AND SEVERITY OF DRUG ABUSE THROUGHOUT THE SYSTEM.

I APPRECIATE YOUR BEING HERE TODAY AND LOOK FORWARD TO HEARING YOUR VIEWS ON THESE AND OTHER IMPORTANT ISSUES RELATING TO DRUG TREATMENT AND THE CRIMINAL JUSTICE POPULATION.

Statement of
Representative William F. Clinger, Jr.
before the
House Select Committee on Narcotics Abuse and Control
Hearing on Drug Treatment in Prisons

May 14, 1991

Mr. Chairman, I am pleased to have the opportunity to appear today to address this important issue. It is clear, the high nation-wide percentage of inmates with a history of drug use has both heightened our awareness, and increased the importance, of intensive drug treatment programs in our prisons. As the relationship between drug abuse and crime becomes more clear, it will be incumbent upon us to help identify where deficiencies exist and remedy the gaps with responsible, well thought out solutions.

To gain a better understanding of this problem, I contacted prison officials in my congressional district.

According to staff who work daily in one institution's Substance Abuse Treatment Programs, there are several areas which warrant attention:

1. There is a clear need for more Drug and Alcohol Programs in the prison environment.

2. The problem of finding acceptable residential programs for those inmates who require it, upon the completion of their incarceration, needs to be addressed and resolved. Some inmates are continued in prison because they have been unable to find appropriate residential treatment in the community.

3. Statistically, many people in substance abuse programs require as much as four to five exposures to treatment before they can successfully work in a recovery program.

4. Prisons are an especially good environment to provide substance abuse education since a large proportion of the inmates have problems in this area. Further, many of them have not been exposed to such education, or did not recognize it as such, prior to incarceration.

In this prison there are 2,026 inmates. 24% of those cite that drugs and/or alcohol led them to commit the crime(s) that led to their incarceration. In the same prison, according to a semi-annual needs assessment, 1,418, or 70%, of the inmates need drug and alcohol treatment. To address this problem, the prison has one full-time employee who sees 98 inmates per week for substance abuse therapy. In addition, staff leads education seminars and conducts individual group therapy, including a six-month residential program inside the prison.

The needs of this prison's population are consisent with the national average. The national average is too high.

As study and investigation on the issue proceeds, I would hope that some of these points be considered. If we are to make progress on this issue, we need to be steadfast in our efforts to eliminate drug abuse, and work hard to rehabilitate those with drug abuse problems.

Thank you.

National Association of State Alcohol and Drug Abuse Directors, Inc.

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John S. Gustafson
New York

First Vice President
Paul Behnke
Arkansas

Vice President for Alcohol Abuse Issues
Janet Zwick
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Vice President for Drug Abuse Issues
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Andrew O'Donovan
Kansas
Robert Anderson
South Dakota
Ed Zborower
Arizona
Ken Stark
Washington

Executive Director
William Butynski

TESTIMONY OF

ROBERT AUKERMAN

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and

VICE PRESIDENT FOR DRUG ABUSE ISSUES

CHAIRPERSON CRIMINAL JUSTICE SYSTEM

for the

NATIONAL ASSOCIATION OF STATE ALCOHOL AND

DRUG ABUSE DIRECTORS

before the

SELECT COMMITEE ON NARCOTICS ABUSE AND CONTROL

MAY 14, 1990

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GOOD MORNING, MR.CHAIRMAN AND MEMBERS OF THE SELECT COMMITTEE. THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY TO DISCUSS SUBSTANCE ABUSE TREATMENT WITHIN CORRECTIONAL FACILITIES.

MY NAME IS ROBERT AUKERMAN, I AM THE DIRECTOR OF THE ALCOHOL AND DRUG ABUSE DIVISION FOR THE COLORADO DEPARTMENT OF HEALTH AND AM APPEARING BEFORE YOU TODAY AS THE VICE PRESIDENT FOR DRUG ABUSE ISSUES AND THE CHAIRPERSON OF THE CRIMINAL JUSTICE COMMITTEE FOR THE NATIONAL ASSOCIATION OF STATE ALCOHOL AND DRUG ABUSE DIRECTORS (NASADAD). NASADAD IS A NOT-FOR-PROFIT ORGANIZATION WHOSE MEMBERSHIP IS COMPRISED EXCLUSIVELY OF THE STATE AND TERRITORIAL OFFICIALS DESIGNATED BY THE GOVERNORS TO ADMINISTER THE PUBLICLY FUNDED ALCOHOL AND OTHER DRUG ABUSE PREVENTION AND TREATMENT SYSTEM.

A. CONTINUED NEED FOR SUBSTANCE ABUSE TREATMENT PROGRAMS IN CORRECTIONAL INSTITUTIONS.

IN AMERICA, OVER THE LAST TEN YEARS THE INCARCERATION RATE HAS MORE THAN DOUBLED. THIS COUNTRY IS NOW #1 IN THE WORLD. OF EVERY 100,000 AMERICANS TODAY, 426 ARE BEHIND BARS. IN COMPARISON:

SOUTH AFRICA-333; SOVIET UNION-268; GREAT BRITAIN-97; SPAIN-76; ITALY-60; AND THE NETHERLANDS-40.

AS OF 1989 THERE ARE OVER 710,000 AMERICANS IN JAIL AND **OVER 70% WERE ARRESTED ON DRUG RELATED CHARGES.** ACCORDING TO THE MOST RECENT STATISTICS RELEASED BY THE DEPARTMENT OF JUSTICE, IN 1988 THERE WERE OVER 1 MILLION ADULTS ARRESTED FOR DRUG VIOLATIONS.

A 1987 SURVEY CONDUCTED BY THE AMERICAN JAIL ASSOCIATION FOUND THAT OF THE 1,687 JAILS SURVEYED APPROXIMATELY ONLY 7% OF AN AVERAGE DAILY INMATE POPULATION OF 192,461 WERE ENROLLED IN DRUG TREATMENT PROGRAMS. EVEN FOR JAILS WITH DRUG TREATMENT PROGRAMS, ONLY 13% OF THE INMATE POPULATION RECEIVED DAILY TREATMENT. A SEPTEMBER/ OCTOBER 1990 ARTICLE ON THE EXTENT OF DRUG TREATMENT PROGRAMS IN PRISONS IN AMERICAN JAILS MAGAZINE CONCLUDES:

> "DESPITE THE HIGH PREVALENCE OF DRUG ABUSE AMONG INMATE POPULATIONS, AND A GROWING AWARENESS THAT UNTREATED DRUG ABUSERS HAVE A NEGATIVE IMPACT ON ALL SEGMENTS OF SOCIETY, MOST JAILS DO NOT HAVE ADEQUATE DRUG TREATMENT SERVICES."

WITH HIGHER RATES OF ARREST FOR DRUG-RELATED CRIMES, THERE HAS BEEN AN INCREASING REALIZATION THAT EFFECTIVE TREATMENT PROGRAMS NEED TO BE IMPLEMENTED THROUGHOUT THE CRIMINAL JUSTICE SYSTEM. AT THE PRESENT TIME, IT IS ESTIMATED THAT ONLY 15% OF ADDICTED PRISONERS ARE RECEIVING ANY KIND OF TREATMENT IN THE FEDERAL AND STATE CORRECTIONAL SYSTEMS.

THE URGENCY FOR COMPREHENSIVE TREATMENT PROGRAMS THROUGHOUT ALL LEVELS OF OUR CRIMINAL JUSTICE SYSTEM IS REINFORCED BY THE FACT THAT MOST OFFENDERS WILL RETURN TO THE STREETS IN A RELATIVFLY SHORT PERIOD OF TIME. IF THEY DO NOT ACQUIRE THE SKILLS TO LIVE AN ALCOHOL/DRUG FREE LIFESTYLE WHILE INCARCERATED OR UNDER SUPERVISION OF THE CRIMINAL JUSTICE SYSTEM, THEY ARE MORE LIKELY TO REVERT TO THE BEHAVIOR THAT RESULTED IN THEIR INITIAL ARREST, POSING AN INCREASED RISK AND COST TO SOCIETY.

WE MUST OFFER DRUG DEPENDENT OFFENDERS THE OPPORTUNITY TO RECOVER FROM THEIR ADDICTIONS AND LIVE PRODUCTIVE LIVES IN OUR SOCIETY. THE URGENCY OF THIS SITUATION LEADS NASADAD TO URGE THE UNITED STATES CONGRESS TO FORMULATE A DRUG TREATMENT POLICY THAT WILL BEGIN TO FIND A SOLUTION TO THESE OVERWHELMING PROBLEMS. WE

BELIEVE THE FOUNDATION OF A BLUEPRINT FOR THESE POLICIES CAN BE FOUND.

WHILE THERE REMAINS MUCH TO BE DONE TO EXPAND TREATMENT SERVICES WITHIN PRISONS, A NUMBER OF STATES HAVE UNDERTAKEN EFFORTS TO ESTABLISH TREATMENT PROGRAMS FOR INCARCERATED INDIVIDUALS. THE FOLLOWING INFORMATION ILLUSTRATES THE EXPERIENCES OF THE STATES IN PROVIDING SUBSTANCE ABUSE TREATMENT TO INMATES.

B. EXAMPLES OF STATE PROGRAMS

1. NEW YORK

IN NEW YORK STATE ALONE, BETWEEN THE YEARS 1984 AND 1989, ANNUAL DRUG COMMITMENTS TO STATE CORRECTIONAL FACILITIES INCREASED BY ALMOST FOUR HUNDRED PERCENT (400%). AS OF DECEMBER 1, 1990, OVER 18,000 OR ONE-THIRD (33%) OF ALL STATE INMATES WERE DRUG COMMITMENTS. IT IS ESTIMATED THAT IF PRESENT TRENDS PERSIST, THE PRISON POPULATION IN NEW YORK STATE WILL RISE FROM THE CURRENT LEVEL OF 55,000 TO OVER 71,000 BY THE YEAR 2000. DRUG OFFENDERS WILL LIKELY COMPRISE ALMOST 40 PERCENT OF ALL MALE INMATES. IN ADDITION, MOST INMATES AT THE STATE AND LOCAL LEVELS AND THOSE UNDER SUPERVISION OF PROBATION HAVE DRUG ABUSE PROBLEMS. ABOUT 74 PERCENT OF STATE INMATES ARE IDENTIFIED DRUG USERS.

RECOGNIZING THE NEED TO PROVIDE SPECIALIZED SERVICES FOR THIS TARGET GROUP, THE NEW YORK STATE DIVISION OF SUBSTANCE ABUSE SERVICES (DSAS), IN COOPERATION WITH THE NEW YORK DIVISION OF CORRECTIONAL SERVICES (DOCS), AND OTHER STATE AND MUNICIPAL AUTHORITIES, EMBARKED UPON COORDINATED EFFORTS TO PROVIDE SUBSTANCE ABUSE PROGRAMS FOR THOSE INVOLVED IN THE CRIMINAL JUSTICE SYSTEM AS LONG AGO AS 1977. TODAY, A DIVERSIFIED ARRAY OF PROGRAMS EXIST; THE COMPONENTS OF WHICH ADDRESS THE SUBSTANCE ABUSER AT DIFFERENT LEVELS WITHIN THE CORRECTIONAL SETTING.

- **STAY'N OUT**

IN 1977, THE STATE DIVISION OF SUBSTANCE ABUSE SERVICES (DSAS) INITIATED FUNDING FOR RESIDENTIAL SUBSTANCE TREATMENT PROGRAMS WITHIN CORRECTIONAL SETTINGS. THERAPEUTIC COMMUNITIES WERE ESTABLISHED IN THE NEW YORK DEPARTMENT OF CORRECTIONS SERVICES (DOCS) ARTHUR KILL CORRECTIONAL FACILITY FOR MALES (70 BEDS) AND THE BAYVIEW CORRECTIONAL FACILITY FOR WOMEN (40 BEDS). IN 1988, AN ADDITIONAL 35 BEDS WERE ADDED TO ARTHUR KILL. KNOWN AS THE STAY'N OUT PROGRAM, THE PROJECT HAS SERVED FOR A MODEL FOR OTHER PROGRAM DEVELOPMENT.

* RIKERS ISLAND KEY EXTENDED ENTRY PROGRAM (KEEP)

THE KEEP PROGRAM AT RIKERS ISLAND CORRECTIONAL FACILITY, IMPLEMENTED IN 1987 BY THE SUBSTANCE ABUSE DIVISION IN CONJUNCTION WITH THE NEW YORK CITY DEPARTMENT OF CORRECTIONAL SERVICES AND THE MONTEFIORE RIKERS ISLAND FACILITY, OFFERS DRUG-RELATED SERVICES TO INMATES. STATE STAFF DESIGNED, IMPLEMENTED, AND ADMINISTERED THIS METHADONE MAINTENANCE PROGRAM. SERVICES ARE PROVIDED FOR UP TO 400 CLIENTS AT THREE SEPARATE SITES IN THE FACILITY. DISCHARGED INMATES ARE THEN PROVIDED A TREATMENT SLOT IN A COMMUNITY-BASED KEEP PROGRAM. THE MAJOR GOALS OF THE RIKER ISLAND KEEP PROGRAM ARE TO PREVENT THE RELAPSE OF INMATES TO SUBSTANCE ABUSE AND NEEDLE-SHARING UPON RELEASE FROM THE CORRECTIONAL INSTITUTION AND TO OFFER THE OPPORTUNITY TO BREAK THE CYCLE OF ADDICTION--INCARCERATION--READDICTION. THE KEEP PROGRAM PROVIDES A VIABLE TREATMENT OPTION FOR THOSE WHO PREVIOUSLY AVOIDED MAKING A COMMITMENT TO TREATMENT, AND IT IS ALSO RECOGNIZED AS A POWERFUL AIDS PREVENTION STRATEGY.

* ALCOHOL AND SUBSTANCE ABUSE TREATMENT PROGRAM (ASAT)

AT THE SAME TIME STAY'N OUT WAS IMPLEMENTED, THE NEW YORK CORRECTIONS AGENCY TOOK STEPS TO ESTABLISH THEIR OWN IN-HOUSE ALCOHOL AND SUBSTANCE ABUSE PROGRAM--ASAT. ASAT PROVIDES A

COMPREHENSIVE RANGE OF SERVICES FROM EARLY IDENTIFICATION AND INTERVENTION TO TREATMENT, AND HAS GROWN FROM ITS INITIAL INVOLVEMENT IN ONE FACILITY TO ITS PRESENT LEVEL OF ACTIVITY IN 60 OF THE 63 STATE FACILITIES. TREATMENT PROGRAMMING IS EITHER RESIDENTIALLY-BASED, WHERE THE INMATE LIVES IN A UNIT SEPARATED FROM THE GENERAL POPULATION AND IS INVOLVED IN SERVICES FOR A PORTION OF EACH WEEK DAY, OR CONDUCTED ON AN OUTPATIENT BASIS, WHERE THE INMATE IS PLACED IN THE GENERAL POPULATION AND ATTENDS REGULAR GROUP THERAPY AND COUNSELING SESSIONS AS PART OF OVERALL INSTITUTIONAL PROGRAMMING. APPROXIMATELY 21,400 INMATES WERE SERVED IN 1990.

2. NEW JERSEY

IN THE STATE OF NEW JERSEY AS OF JANUARY 1991, THE TOTAL NUMBER OF ADULT INMATES IN THE PRISON AND YOUTH COMPLEXES WAS 18,077 INMATES (THIS DOES NOT INCLUDE COUNTY WAITING LISTS OR COMMUNITY PROGRAMS). AS THE MOST RECENT DEPARTMENTAL DATA INDICATES, 3,459 OR 19% OF ALL ADULT INMATES ARE INVOLVED IN A WIDE RANGE OF SUBSTANCE ABUSE PROGRAMS IN THE ADULT PRISON SYSTEM. OF THE 3,459 ADULTS, APPROXIMATELY 670 OR 19% OF THOSE INVOLVED IN TREATMENT INSIDE THE INSTITUTION ARE INVOLVED IN PROGRAMS WHICH ARE FULL TIME OR MEET A MINIMUM OF FOUR TIMES PER WEEK. THE REMAINING 2,789 OR 81% OF THOSE

INVOLVED IN TREATMENT ARE INVOLVED PRIMARILY IN NA, AA, GROUP OR INDIVIDUAL COUNSELING, ETC., MOST OF WHICH MEET WEEKLY OR BI-WEEKLY. THEREFORE, 4% OF THE TOTAL ADULT POPULATION IS INVOLVED IN FULL-TIME SUBSTANCE ABUSE PROGRAMMING AND 15% ARE INVOLVED IN PART-TIME SUBSTANCE PROGRAMMING.

AN EXAMPLE OF A TREATMENT PROGRAM IS THE "PERSONS INCARCERATED ENTERING RECOVERY" OR PIER PROGRAM. THIS PROGRAM IS A PRISON-BASED THERAPEUTIC COMMUNITY AT SOUTHERN STATE CORRECTIONAL FACILITY IN DELMONT. THE PIER PROGRAM PROVIDES INTENSIVE SUBSTANCE ABUSE TREATMENT SERVICES FOR 90 INMATES. THE AVERAGE LENGTH OF TREATMENT IS 12 MONTHS. THE ANNUAL COST OF THE PIER PROGRAM IS $4,253 PER INMATE ABOVE THE NORMAL PRISON COST OF HOUSING THE INMATE. **HOWEVER,** SINCE THE INTENT IS TO PROVIDE INTENSIVE TREATMENT WITHIN THE INSTITUTION, FOLLOWED WITH PARTICIPATION IN COMMUNITY PROGRAMS, AN AVENUE IS PROVIDED FOR PRISON RELEASE AT FIRST ELIGIBILITY, **THUS FREEING MUCH NEEDED BEDSPACE AND REDUCING COST OF LENGTHY INCARCERATION.**

RESEARCH DEMONSTRATES THAT CONTINUITY OF CARE AFTER RELEASE FROM A PRISON THERAPEUTIC COMMUNITY IMPROVES CHANCES FOR SUCCESSFUL REHABILITATION. THEREFORE, DEPENDING ON THE INMATE'S

NEED FOR ADDITIONAL TREATMENT AND SUPERVISION, THE INMATE WHO HAS COMPLETED TREATMENT IS REFERRED TO A COMMUNITY RELEASE OR SPECIALIZED PAROLE PROGRAM FOR FOLLOW-UP TREATMENT AND SUPPORT IN THE COMMUNITY. THE COMMUNITY PROGRAMS WHICH THE INMATE CAN BE REFERRED TO ARE: MUTUAL AGREEMENT PROGRAM (IN-PATIENT OR OUT-PATIENT), HALFWAY HOUSE (WITH OUT-PATIENT COUNSELING), INTENSIVE SURVEILLANCE AND SUPERVISION PAROLE, OR ELECTRONIC MONITORING.

THE NEED FOR ADDITIONAL TREATMENT PROGRAMS IS DEMONSTRATED BY AN INCREASE OF 359% SINCE 1980, OF THE NUMBER OF PEOPLE ARRESTED IN NEW JERSEY FOR SALE AND MANUFACTURE OF DRUGS. ADDITIONALLY, A SURVEY OF 1,034 MALE INMATE INTERVIEWS, CONDUCTED AT THE GARDEN STATE RECEPTION CENTER, INDICATED THAT 66% NEEDED TREATMENT FOR A SUBSTANCE ABUSE PROBLEM AND 55% REPORTED THAT THEIR CURRENT OFFENSE WAS DRUG RELATED, I.E., HIGH AT TIME OF OFFENSE OR NEEDED MONEY TO BUY DRUGS. EIGHTY-FIVE PERCENT (85%) OF THOSE REPORTING DRUG/ALCOHOL USE STATED THAT THEY USED DRUGS MORE THAN 10 YEARS. THE INMATES INTERVIEWED WHO ADMITTED USE (810 INMATES) REPORTED THAT THE **WEEKLY** COST OF THEIR SUBSTANCE USE WAS $255,165.

3. FLORIDA

THE FLORIDA DEPARTMENT OF CORRECTIONS HAS LAUNCHED A SIGNIFICANT EFFORT IN THE AREA OF SUBSTANCE ABUSE TREATMENT PROGRAMMING SERVICES DESIGNED FOR DELIVERY TO MEMBERS OF THE INMATE POPULATION WHO ARE IDENTIFIED AS HAVING HISTORIES OF SUBSTANCE AND/OR ADDITION PROBLEMS. THIS PROGRAMMING EFFORT ADDRESSES THE SUBSTANCE TREATMENT NEEDS OF IDENTIFIABLY TARGETED MEMBERS OF FLORIDA'S INMATE POPULATION THROUGH THE USE OF A MODEL ENCOMPASSING A COMPREHENSIVE BATTERY OF SUBSTANCE TREATMENT SERVICES. THE PROGRAM PROVIDES LINKAGES BETWEEN INSTITUTIONAL AND COMMUNITY RESOURCES AND HAS CREATED NEW SERVICES WITHIN THE INTENT OF THE FLORIDA LEGISLATURE.

IT IS ESTIMATED THAT OF THE 44,000 INMATES IN THE FLORIDA CORRECTIONAL SYSTEM 85% ARE DRUG RELATED ADMISSIONS. DUE TO THIS STAGGERING NUMBER OF INMATES THAT HAVE SUBSTANCE ABUSE PROBLEMS, THE STATE OF FLORIDA HAS DEVELOPED A COMPREHENSIVE STATEWIDE SUBSTANCE ABUSE PROGRAM WHICH INCLUDES AN INITIAL ASSESSMENT PHASE AND A TIER SYSTEM OFFERING VARYING DEGREES OF TREATMENT FOR IDENTIFIED SUBSTANCE ABUSERS.

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WHILE MORE THAN 50% OF THE INMATES RECEIVED ADMIT TO A SERIOUS PROBLEM WITH ONE OR MORE SUBSTANCES OF ABUSE, IT IS CLEAR THAT INTENSIVE THERAPY WILL NOT BE POSSIBLE FOR ALL. THEREFORE, AN ASSESSMENT PROCEDURE HAS BEEN IMPLEMENTED AT ALL RECEPTION LOCATIONS. AN INMATE SENTENCED TO THE DEPARTMENT OF CORRECTIONS UNDERGOES AN ASSESSMENT PROCEDURE TO DETERMINE THE SEVERITY OF HIS/HER SUBSTANCE ABUSE ADDICTION AS WELL AS THEIR READINESS FOR TREATMENT. THROUGH THE CLASSIFICATION PROCESS, A RECOMMENDATION TO A LOCATION WHERE THE APPROPRIATE LEVEL OF TREATMENT IS IN PLACE IS MADE.

* TIER I

THIS IS A 40 HOUR PROGRAM SPECIFICALLY DESIGNED TO ADDRESS THE NEEDS OF OFFENDERS WHO; (1) HAVE LESS THAN A SEVERE SUBSTANCE ABUSE HISTORY, (2) ARE BELIEVED TO HAVE A SEVERE SUBSTANCE ABUSE PROBLEM BUT ARE DENYING SUCH EXISTS, AND ARE NOT CONSIDERED READY FOR TREATMENT, AND (3) DUE TO A VERY SHORT SENTENCE, WILL NOT HAVE THE OPPORTUNITY TO GO THROUGH A LONGER PROGRAM. THIS STEP WILL INTRODUCE GROUP COUNSELING TECHNIQUES AND MORE IMPORTANTLY, WILL SERVE AS THE BEGINNING POINT FOR ESSENTIAL FOLLOW-UP TREATMENT. FOR THE YEARS 1990-91, TIER I IS IN 24 LOCATIONS WITH A CAPACITY OF 1005 SLOTS AND TREATED 5,940 INMATES.

* TIER II

THIS IS AN INTENSIVE EIGHT WEEK RESIDENTIAL MODIFIED THERAPEUTIC COMMUNITY PROGRAM HOUSED WITHIN A CORRECTIONAL INSTITUTION DESIGNED FOR INMATES WITH SERIOUS SUBSTANCE ABUSE PROBLEMS. THIS LEVEL OF TREATMENT IS AIMED AT THOSE INMATES WHO WILL NOT BE IN THE CORRECTIONAL SYSTEM LONG ENOUGH TO PARTICIPATE IN A MORE EXTENSIVE PROGRAM. THERE ARE 7 LOCATIONS WITH A TOTAL CAPACITY OF 261 SLOTS WHICH TREATED 1,566 INMATES DURING 1990-91.

* DRUG INTERVENTION CENTER

THIS CENTER IS THE NEWEST COMPONENT IN THE DEPARTMENT OF CORRECTIONS (DOC) SUBSTANCE ABUSE PROGRAMS. THIS IS A STATEWIDE SYSTEM OF REGIONAL DRUG INTERVENTION CENTERS FOR THE PURPOSE OF HOUSING MINIMUM OR MEDIUM CUSTODY INMATES WHO NEED DRUG TREATMENT. THE EMPHASIS IS ON THOSE CONVICTED OF DRUG OFFENSES, THEFT, OR BURGLARY, AND WHO HAVE A CUMULATIVE SENTENCE OF FIVE YEARS OR LESS. THIS IS AN INTENSIVE FOUR MONTH TREATMENT PROGRAM IN WHICH INMATES ARE INVOLVED IN THE THERAPEUTIC COMMUNITY PROCESS 24 HOURS A DAY, SEVEN DAYS A WEEK. THERE ARE 2 LOCATIONS THAT HAVE A TOTAL CAPACITY OF 203 AND TREATED 609 INMATES DURING 1990-91.

* TIER III

THIS IS A FULL SERVICE RESIDENTIAL THERAPEUTIC COMMUNITY PROGRAM. THIS COMPONENT OF TREATMENT IS 9 TO 12 MONTHS IN LENGTH AND IS CURRENTLY BEING PROVIDED IN A FEMALE INSTITUTION, A MALE YOUTHFUL OFFENDER INSTITUTION, AND AN ADULT MALE INSTITUTION. AT THESE THREE LOCATIONS THERE IS A TOTAL CAPACITY OF 338 SLOTS WHICH TREATED 507 INMATES DURING 1990-91. ADDITIONALLY, THE DEPARTMENT HAS CONTRACTS WITH COMMUNITY BASED DRUG TREATMENT PROGRAMS STATEWIDE TO PROVIDE THIS SERVICE FOR ELIGIBLE INMATES APPROACHING THE END OF THEIR SENTENCES. THESE CONTRACT FACILITIES ARE DESIGNATED AS COMMUNITY TIER III THERAPEUTIC COMMUNITIES. PRESENTLY THERE ARE SEVEN SUCH FACILITIES WHICH CONTRACTED FOR 54 BEDS AND FOR THE YEAR 1990-91 TREATED 108 INMATES.

* TIER IV

THIS TIER IS DESIGNED SPECIFICALLY TO PROVIDE COUNSELING SERVICES TO INMATES ASSIGNED TO COMMUNITY CORRECTIONAL CENTERS BY MEANS OF CONTRACT SERVICES. THIS OUTPATIENT/AFTERCARE TREATMENT STRATEGY FOCUSES ON RELAPSE PREVENTION AND SUPPORTIVE THERAPY. THIS IS A TEN WEEK AFTERNOON AND/OR EVENING PROGRAM IN WHICH INMATES PARTICIPATE PRIOR TO OR AFTER WORK. THERE ARE 11 LOCATIONS THAT HAVE

A COMBINED CAPACITY OF 330 INDIVIDUALS AND FOR THE YEAR 1990-91 HAVE TREATED 1,650 INDIVIDUALS.

THE FLORIDA DEPARTMENT OF CORRECTIONS HAS WORKED DILIGENTLY TO PLAN AND IMPLEMENT COMPREHENSIVE INSTITUTIONAL AND COMMUNITY BASED PROGRAMS. THESE PROGRAMS STRIVE TO ESTABLISH A FUNCTIONAL, COST EFFECTIVE CONTINUUM OF CARE FOR INCARCERATED INDIVIDUALS, WHILE PROVIDING NECESSARY LINKAGES ESSENTIAL TO TRANSITION OF INMATES BACK INTO SOCIETY WITH THE KNOWLEDGE AND SOCIAL SKILLS NECESSARY TO LEAD A DRUG FREE LIFE. IT IS BELIEVED THAT A VIABLE WORKING MODEL HAS BEEN DEVELOPED THAT WILL OFFER SERVICES TO INMATES AND, ULTIMATELY, AFFORD THEM THE OPPORTUNITY AND APPROPRIATE LINKAGES TO CONTINUE TREATMENT AFTER INCARCERATION.

THIS SITUATION BRINGS US TO RECOMMEND THAT IN-PRISON AND IN-JAIL DRUG TREATMENT PROGRAMS SHOULD BE IMMEDIATELY IMPLEMENTED WITH SUFFICIENT EXPERTISE. THESE PROGRAMS WILL BE AN IMPORTANT FIRST STEP IN THE REHABILITATION OF THE DRUG DEPENDENT INMATE POPULATION. SUCCESSFUL DRUG TREATMENT PROGRAMS CHANGE DRUG USING BEHAVIOR AND INSTALL A SENSE OF HOPE AND HIGH SELF-ESTEEM IN INDIVIDUALS WHICH OFTEN RESULTS IN LOWER RECIDIVISM RATES. THE CONSEQUENCES OF IGNORING THIS URGENT PROBLEM ARE GRAVE. HIGH RECIDIVISM RATES

INCREASED VIOLENT CRIME, AND INCREASED BUDGETS FOR PRISON CONSTRUCTION, ARE ALL LIKELY SCENARIOS UNLESS WE ADDRESS THIS PROBLEM IMMEDIATELY.

C. NASADAD RECOMMENDATIONS

WITHOUT THE AVAILABILITY OF EFFECTIVE TREATMENT ALTERNATIVES IN THE CRIMINAL JUSTICE SYSTEM, THE DILEMMAS FACING OUR SOCIETY IN RELATION TO DRUGS AND CRIME WILL CONTINUE TO ESCALATE. THE FACT THAT THE UNITED STATES PRISON AND JAIL POPULATION HAS MORE THAN DOUBLED IN THE PAST TEN YEARS LEADS US TO RECOMMEND NEW AND INNOVATIVE PROGRAMS. LEGISLATION SUCH AS H.R. 730 "DRUG REHABILITATION AND RECOVERY PROGRAM FOR PRISONS" BEGIN TO ADDRESS THE CRITICAL TREATMENT NEEDS IN FEDERAL AND STATE PRISONS AS WELL AS IN JUVENILE FACILITIES. THIS BILL SEEKS TO ENSURE THAT THE SERVICES PROVIDED ARE COMPREHENSIVE IN NATURE, INCLUDE A STRONG AFTERCARE COMPONENT, AND ARE LINKED TO COMMUNITY-BASED SERVICES. ALL OF THESE NECESSARY ELEMENTS ENHANCE TREATMENT PROGRAMS' EFFECTIVENESS AND INCREASE THE PROBABILITY THAT DRUG DEPENDENT OFFENDERS WILL LIVE A SUBSTANCE ABUSE FREE LIFE.

NASADAD RECOMMENDS THE FOLLOWING ACTION BE TAKEN AS SOON AS POSSIBLE TO BEGIN TO ADDRESS THESE URGENT PROBLEMS:

- **EXPANSION OF PROGRAMS TO IDENTIFY DRUG DEPENDENT PERSONS ENTERING THE CRIMINAL JUSTICE SYSTEM WITH APPROPRIATE ASSESSMENTS AND REFERRAL INTO DRUG TREATMENT PROGRAMS.**
- **EXPANSION OF CASE MANAGEMENT PROGRAMS SUCH AS TREATMENT ALTERNATIVES TO STREET CRIMES (TASC) FOR THE ASSESSMENT, REFERRAL, AND MONITORING OF OFFENDERS IN COMMUNITY BASED TREATMENT FACILITIES.**
- **CREATION OF SPECIALIZED DRUG TREATMENT PROGRAMS, TO BE OFFERED BY COMMUNITY BASED TREATMENT PROGRAMS, AS AN ALTERNATIVE TO INCARCERATION FOR ELIGIBLE NON-VIOLENT DRUG OFFENDERS.**

- **EXPANSION OF IN-PRISON AND IN-JAIL DRUG TREATMENT PROGRAMS TO BE OFFERED BY EXPERT TREATMENT PERSONNEL AND LINKED WITH COMMUNITY BASED TREATMENT PROGRAMS.**

- **APPROPRIATE REFERRAL TO DRUG TREATMENT PROGRAMS FOR RELEASED DRUG DEPENDENT INMATES AS WELL AS THOSE WHO**

HAVE BEEN PAROLED OR INDIVIDUALS WHO HAVE BEEN PLACED ON PROBATION.

IN CLOSING, MR. CHAIRMAN AND MEMBERS OF THE SELECT COMMITTEE, THE MEMBERSHIP OF NASADAD THANKS YOU FOR THE OPPORTUNITY TO TESTIFY BEFORE YOU ON THIS VERY SERIOUS MATTER FACING AMERICA. CLEARLY, THE STATISTICS SHOW THAT OUR PRISONS AND STREETS ARE OVERWHELMED BY AMERICA'S SUBSTANCE ABUSE PROBLEM, AND IT'S NOT GOING AWAY BY INSTITUTIONALIZING OR IGNORING IT. WE CANNOT MISS THE OPPORTUNITY TO TREAT THE PROBLEM BY TREATING THE OFFENDERS, NOT AS SOCIAL DEVIATES, BUT WITH EFFECTIVE AND SUBSTANTIAL SUBSTANCE ABUSE PROGRAMS. INSTEAD OF SENDING OFFENDERS BACK ON THE STREETS TO CONTINUE THEIR ABUSE, WE'LL BE SENDING THEM OUT WITH THE SKILLS AND KNOWLEDGE TO LIVE SUBSTANCE-FREE LIVES AS PRODUCTIVE, RATHER THAN DESTRUCTIVE, MEMBERS OF OUR SOCIETY. YOUR LEADERSHIP AND SUPPORT IS NECESSARY TO HELP ACCOMPLISH THIS WORTHY GOAL. THANK YOU AGAIN AND WE LOOK FORWARD TO OUR CONTINUED WORKING RELATIONSHIP WITH YOU AND OTHER MEMBERS OF CONGRESS.

STATEMENT OF

DOUGLAS S. LIPTON, Ph.D.

DIRECTOR, RESEARCH INSTITUTE

NARCOTIC AND DRUG RESEARCH, INC.

BEFORE THE

U. S. HOUSE OF REPRESENTATIVES

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

May 14, 1991

RELEASE ONLY UPON DELIVERY

Mr. Chairman, members of the Committee, I am Dr. Douglas S. Lipton, Director of the Research Institute of Narcotic and Drug Research Inc. (NDRI) of New York City. NDRI, a not-for-profit corporation, has since 1967 conducted drug abuse-related research and evaluation. Today, NDRI maintains a Research Institute, a Training Institute, an AIDS Outreach and Prevention Bureau, and a Marketing and Product Development Bureau. Its 210 persons are presently engaged in over forty drug-abuse related projects on behalf of numerous organizations in New York State and in many other states in the rest of the country.

The Research Institute at NDRI is the largest behavioral science research organization focusing on substance abuse in the United States. We concentrate in the following areas: AIDS and IV drug use, the relationship between crime and drugs, drug abuse treatment and prevention evaluation studies. We employ over fifty professional researchers with backgrounds in the social sciences and over eighty clinicians, field staff and support personnel. Many of the staff members are ex-addict and ex-offender professionals whose knowledge and insights about the street drug world have proven invaluable in our research efforts. Almost all of our funding is from research grants and contracts awarded by federal and state agencies.

By way of introducing myself: after I completed my doctoral work in 1963, I became Director of Research and Planning for the New York City Department of Corrections in 1964, directed a plastic surgery with disfigured offenders project for the Social Restoration Research Center in New York 1965-1967, then joined the Governor Rockefeller's Special Committee on Criminal Offenders as Assistant Director. In the early 1970s as Assistant Director of the State Crime Control Council, the State Office of Crime Control Planning, and the State Division of Criminal Justice, I helped

contribute to the crime control efforts in the State. From 1972 to 1988, I served as Director of Research of NDRI as well as Deputy Director of the New York State Division of Substance Abuse Services in charge of drug abuse research. I have evaluated drug abuse control and treatment programs around the world for the United Nations and have authored and co-authored many articles, chapters and books about drugs and crime.

It is a pleasure to appear before you today to testify to what our research and experience show can be done to improve substance abuse treatment within the criminal justice system. Addiction treatment is a critical component of the Nation's war on drugs, and the incarceration of persons found guilty of various crimes who are also chronic substance abusers presents a significant opportunity for treatment. It is significant because these persons would be unlikely to seek treatment on their own, without treatment they are very apt to continue their drug use and criminality after release, and we now have cost effective technologies to effectively treat them while in custody and alter their life styles.

I come with an intention of conveying to you the optimism I feel with respect to the number of "irredeemable" persons (namely, chronic heroin and cocaine users with extensive predatory criminal histories) that can be treated effectively. It is worth noting, Mr. Chairman, that with high rate addict-offenders such as these, who each commit 40 to 60 robberies a year, 70 to 100 burglaries a year , and more than 4000 drug transactions a year, a meager 10% reduction in recidivism means a substantial improvement in our quality of life; and we consistently have been able to substantiate more than a 25% reduction.

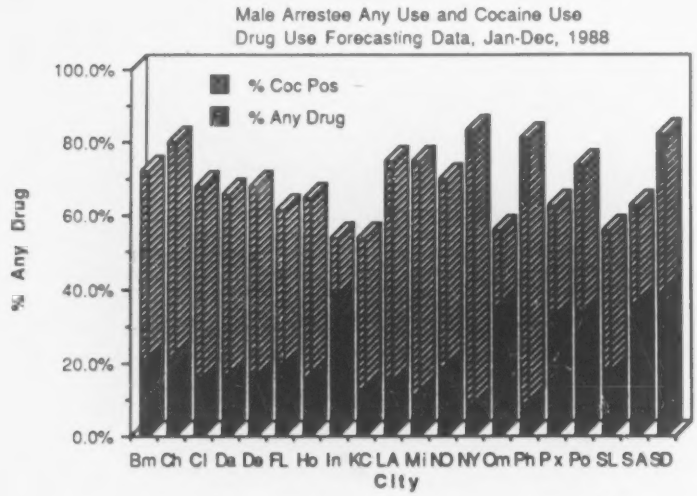
The field of corrections has not had notable rehabilitative successes, and I am responsible, in part, for the pervasive notion that "Nothing Works" which emerged from a summary (Martinson, 1974) of the book I wrote with two colleagues (Robert Martinson and Judith Wilks) that was published in 1975 called *The Effectiveness of Correctional Treatment*. The book emerged at a time when the national media and the social climate were ripe for a shift away from the so-called "rehabilitative era." Liberals and conservatives alike felt that, as James Q. Wilson put it, "belief in rehabilitation requires not merely optimistic but heroic assumptions about the nature of man."

I am a skeptic so when I see successful outcomes for correctional programming, and see it repeated year after year, with a group of offenders unlikely to succeed, it certainly makes me pay attention. When I say success I am referring to reducing recidivism to a statistically significant degree, and by recidivism I mean returning to prior forms of conduct. I not only want to share with you the success of the Stay'n Out Project but also of other programs that have been successful with drug abusing offenders. First, however, a look at the scope of the problem.

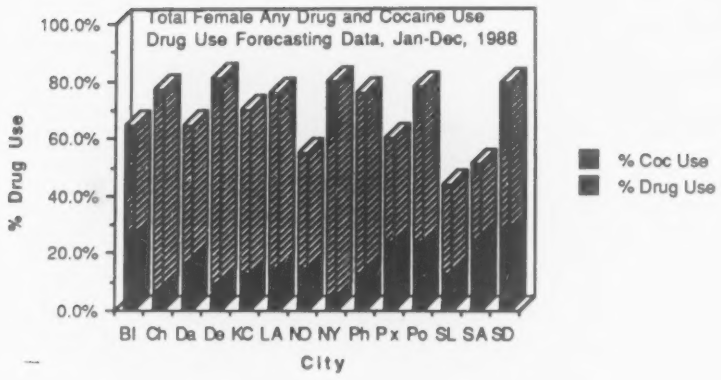
The Scope of The Problem

The great majority of today's jail and prison populations consist of drug abusers. Of the 800,000 inmates that Bureau of Justice Statistics (BJS) statistics indicate are now in Federal and state prisons, and of the 9.7 million that are admitted to the Nation's 3,500 jails each year, probably 50 to 66% are regular users of controlled substances. The National Institute of Justice's Drug Use Forecasting (DUF) data indicate that fifty-five to over eighty percent of arrestees in 22 of our largest cities test positive for one or more drugs *regardless of charge at arrest*. In every DUF city, opiates

have been found in fewer than 20 percent of tested males (except New York where the heroin positive rate has ranged between 17 and 29 percent). In contrast, cocaine levels have been consistently high in most cities. The highest rates of cocaine use -- above 60 percent -- have been found in Miami, New York, Los Angeles and Philadelphia (DUF, 1990). In the figure below, the proportion of the male arrestees with cocaine is marked by a white line on the columns. The columns themselves represent the proportion of male arrestees in twenty cities who were positive by urinalysis for any drug.



Source: National Institute of Justice/Drug Use Forecasting Annual Report, March 1990



Source: National Institute of Justice/Drug Use Forecasting Annual Report, March 1990

In the figure above the proportion of female arrestees with any drugs and with cocaine may be seen. Because several cities currently do not report data for females, the two figures differ in the number of cities reporting. It is important to note the extent of serious drug use among these female arrestees in contrast with the paucity of drug abuse treatment programming available for female prisoners in the contemporary correctional systems around the country.

At the other end of the criminal justice funnel, i.e., at the incarceration level, I believe it is a safe assumption that the proportion of drug using offenders among those incarcerated is higher than even their proportion among arrestees. These men and women in many instances are not just users of single drugs, but use many different drugs and use them mostly in combination with each other and with alcohol. If they are chronic users, as Dr. Johnson's (1986) data would suggest, their drug use pervades

their lifestyle and preoccupies their daily hours. Most of these persons have avoided treatment while active in the community although some have experienced detoxification several times. Their entry into the country's crowded jails and prisons stills their criminal acts for a while, but the problems of prison crowding are of such enormity that for each person incarcerated there is one bound to be released and he or she is highly likely to be an untreated drug user. At least 45 percent of arrestees charged with violent crimes or income-generating crimes like robbery, burglary and theft tested positive for use of one or more drugs according to NIJ Reports (1989).

The relationship between drugs and crime is indisputable after a decade of research documenting how much active addiction accelerates the rate at which individuals commit crimes. Ball et al., Johnson et al. as well as others have shown that the rate of predatory crime rises between 4 and 8 times during periods of active addiction. The increasing rate of cocaine and crack usage and its effects on criminal behavior are well documented. The cost of the drug-related crime problem is now staggering. The National Institute on Drug Abuse (NIDA) estimates the annual cost at $60 billion.

All but eight states are under some kind of court order or consent decree to relieve prison crowding. Much of this prison crowding pressure is directly due to the righteous public outrage regarding drug-related crime and the resultant tougher sentencing practices that have been enacted for repeat offenders and criminals committing drug-related crimes, as well as just the dramatic increase in arrests directly related to crime increases generally. Drug using offenders are a substantial proportion of the pool of persons now flooding the prisons and jails, and this trend of the nineteen eighties appears likely to continue undiminished into the current decade.

Furthermore, the repeater rate of drug offenders is quite high. Up to two-thirds of inmates in some states (e.g., Oregon and Texas) are drug-involved former probationers and parolees. Although data vary across studies, it would appear that drug-using felons are also a primary source of failure on parole. That is, they constitute a disproportionate share of the repeat offenders. Sixty to 75 percent of untreated parolees with histories of heroin and/or cocaine use are reported to return to heroin and/or cocaine use within three months after release, and become reinvolved in criminal activity (Wexler 1988). The "revolving door" analogy epitomizes the situation with hard drug-using offenders. Since a great proportion of American drug users are processed through some part of the criminal justice system during their drug using careers, it makes a great deal of sense to consider that system as a location for treatment. Most inmates have not been treated in the community and state, when asked, that they have no particular interest in entering treatment. Thus, the criminal justice system is a major opportunity to bring to bear the state-of-the-art in drug abuse treatment for this otherwise elusive population.

Overall, then, the U. S. prison population has grown about 55 percent over the past eight years largely fueled by the major influx of drug using offenders. These offenders, largely recidivists, are responsible for a relatively large amount of crime, and among them, the most predatory, the heroin-using "violent predators", when compared with non-drug using offenders committed: 15 times as many robberies, 20 times as many burglaries, and 10 times as many thefts (Chaiken). Active drug use not only accelerates the users' crime rate, but also the crime quality is at least as violent, or more so, than that of non-drug using counterparts. It is interesting to note in this connection that the times in the last two decades

that the homicide rate in the United States has peaked corresponds to the cocaine and crack wars for control of drug distribution (Goldstein, 1991).

Treatment

Very few inmates, despite the demonstrated need for treatment services, actually receive treatment for their addiction, either before, during or after their incarceration. DUF data show that, on the average, only four percent of arrestees are receiving treatment at the time of arrest, and about 22 percent of arrestees have ever received treatment services of any kind. In a recent street survey of active heroin and cocaine users that we conducted in New York City (as part of Pathways into Treatment project), 70% had never been in treatment and had no current intention of ever entering (although some had experienced detoxification). In 1979, the National Institute on Drug Abuse conducted a comprehensive survey of drug abuse treatment programs in prisons (NIDA, 1981). The survey identified 160 prison treatment programs serving about 10,000 inmates (four percent of the prison population). Chaiken estimated that in 1987, 11.1 percent of the inmates in the 50 states were in drug treatment programs (Chaiken, 1989). Although this represents a sizeable increase (from 10,500 inmates in 1979 to 51,500 inmates in 1987), the vast majority of inmates with substance abuse problems still do not receive treatment while in prison.

While there is still no consensus about the percentage of offenders being treated for drug use, recent incomplete surveys of treatment for incarcerated drug abusers show: thirty-nine states using preliminary assessment procedures with newly sentenced inmates; forty-four states allowing Narcotics Anonymous, Cocaine Anonymous or Alcoholics Anonymous self-help group meetings once or twice a week; forty-four

states having some form of short-term (35 to 50 hours) drug education programming; thirty-one states having some form of individual counseling available for drug users where a counselor or therapist meets with an individual inmate occasionally during the week; thirty-six states having group counseling in which small groups of inmates meet once or twice weekly with a therapist; and, 30 states having some type of intensive residential program, often based on the therapeutic community (TC) model. Most optimistically, less than 20 percent of identified drug using offenders are believed to be served by these programs. (Frohling, 1989)

Treatment Works

Prior to 1980, relatively few outcome research studies of TCs in prison settings had been conducted. Recently published findings regarding the Stay'n Out Program by Wexler, Lipton and Falkin and colleagues (1989, 1990) and the Cornerstone Program by Gary Field (Field 1984, 1989) substantiate the significant accomplishments of correctional-based TCs with incarcerated drug abusing felons.

The Stay'n Out program is a therapeutic community for the treatment of incarcerated drug offenders which has been identified as a national model. Stay'n Out began as a joint effort by the New York State Division of Substance Abuse Services, which funded the program during its first years, New York Therapeutic Communities, which operates it, and the New York State Department of Correctional Services which currently funds it. It has two sites: a program for male offenders at the New York State Arthur Kill Correctional Facility on Staten Island established in 1977, and one for females, opened in 1978 at the Bayview Correctional Facility in Manhattan. Currently, there are now four treatment units at the Arthur Kill

Correctional Facility, with about 35 beds per unit (a total capacity of 143 beds), and one female treatment unit at the Bayview Correctional Facility, with 40 beds. Also, Stay'n Out recently opened and now operates Serendipity House—a halfway house in Brooklyn for Stay'n Out graduates. (Parenthetically, I wish to add that such a facility was our strong recommendation after conducting the research on the program's effectiveness.)

In 1984, the National Institute on Drug Abuse provided a grant to Narcotic and Drug Research, Inc. to evaluate Stay'n Out and compare it to other prison drug abuse treatment programs. The evaluation was designed to test the proposition that effective treatment of substance abusers is possible within prison (Wexler, Falkin and Lipton, 1990). A large-scale, quantitative analysis was conducted relating several measures of treatment outcome (e.g., rearrest, reincarceration) to both client characteristics and program attributes (time in program and termination status). The study included males and females as well as treatment and no-treatment comparison groups. Statistical analyses were performed to test whether the Stay'n Out therapeutic community is more effective at reducing recidivism than no treatment and alternative prison-based drug treatment modalities, and whether increases in time-in-program would be related to reductions in recidivism, among other questions. Both were affirmed, with the main finding being that maximum reductions in recidivism occur for those inmates spending nine to twelve months in program.

Since the program began, nearly 1,500 men and over 500 women were admitted to treatment. The aim of the program is to treat felony offenders for their drug abuse and related problems so that they are less likely to

recidivate after leaving prison. Inmates selected for the programs are recruited at state correctional facilities. The criteria for admission to the program are: official history of drug abuse (or indication of involvement in the drug culture); at least 18 years of age; evidence of positive institutional participation; no history of extensive violence, arson, sex crimes, or mental illness; that inmates be no more than 12 months nor less than six months away from their first parole hearing.

On average, males in the Stay'n Out program have previously been convicted four times and have been incarcerated for four years (prior to admission into Stay'n Out). Most of the offenders are in prison for robbery (43%), drug sales (18%), or burglary (18%). Drug abusers in the Stay'n Out program have been heavily involved in drug use since sixteen and a half on the average. Seventy-three percent abused opiates; 77 percent have abused cocaine (and other stimulants). On the average, two previous attempts at changing their lifestyle have failed (about 18 months of treatment combined).

The Stay'n Out programs at Arthur Kill and Bayview are therapeutic communities modified to fit into a correctional institution. (See Wexler and Williams [1986] for a full description of the program). During the early phase of treatment, the major clinical thrust involves observation and assessment of client needs and problem areas. Orientation to the prison therapeutic community procedures occurs through individual counseling, encounter sessions, and seminars. At the outset clients are given low-level jobs and granted little status. During the latter phases of the recovery process, residents are given opportunities to earn higher level positions and increased status through sincere involvement in the program and hard work. Encounter groups and counseling sessions are more in-depth, and

focus on the areas of self-discipline, self-worth, self-awareness, respect for authority, and acceptance of guidance for problem areas. Seminars take on a more intellectual nature. Debate is encouraged to enhance self-expression and to increase self-confidence.

Stay'n Out clients are housed in units isolated from the general prison population, however, they do attend morning activities with other prisoners, and eat in a common dining room. Most program staff are ex-addicts who are graduates of community-based therapeutic communities as well as ex-offenders. Employed by New York Therapeutic Communities, Inc. (NYTC), they act as role models demonstrating that persons just like themselves can be successfully rehabilitated. NYTC is contracted with annually by the New York State Department of Correctional Services to provide the entire Stay'n Out program at both facilities. All but one of the units are staffed by a unit director and three counselors; one unit at Arthur Kill has only two counselors.

Upon release, participants are encouraged to seek further substance abuse treatment at cooperating community-based therapeutic communities (TCs). About half the program graduates actually continue in residential programs. Extensive involvement with a network of such community TCs is central to the program's operation. Staff and upper residents of community TCs visit Stay'n Out on a regular basis to recruit resident inmates for their programs. These visitors provide inspiration since they are ex-addicts and ex-felon role models who are leading productive lives. Now, Stay'n Out has added a halfway house facility to its program, but during the course of our evaluation no such facility was available for Stay'n Out graduates.

The evaluation research design compared a male TC treatment group (N=435) and a female TC group (N=247) to no-treatment control groups and alternative treatment groups. The male treatment group was compared to the no-treatment control group (N=159), which consisted of inmates who were on a waiting list for the program. They met all the criteria for admission except the parole time eligibility criterion and, therefore, completed their prison term without treatment. The male treatment group was also compared to a milieu treatment group (N=576), which offered a less intensive treatment than the TC (i.e., time was less structured; there was no hierarchy of jobs or social roles; counselors were not ex-addicts or ex-offenders but trained correctional officers; good conduct in the program was not rewarded with greater responsibility; and interaction with community TCs was less extensive). In addition, the male treatment group was compared to a counseling group (N=261), which only received individual and group counseling once a week. The female treatment group was compared to a no-treatment control group (N=38) and a counseling treatment group (N=113); these groups were similar to their male counterparts (i.e., the control group met the basic criteria for admission but did not receive treatment, and the alternative treatment group received only counseling services).

In general, the background characteristics of the samples were comparable, and multivariate statistical analyses were performed to control for the possible confounding effects of any differences on treatment outcomes. The groups were compared according to several recidivism measures: the percentage arrested, the mean number of months until arrest, the percentage positively discharged from parole, and the percentage not reincarcerated. The sampling time-frame was based on

inmates released from prison between 1977 and 1984; the follow-up period (which ended in 1986), therefore, ranged from three to nine years, depending on the year prisoners were released (almost all had at least three years, many had six years of follow up).

Statistical analyses were performed to compare the effectiveness of TC treatment with alternative interventions and no treatment and to assess the relationship between treatment outcomes and time in treatment. The across group comparisons yielded mixed results (i.e., when compared to the other groups, the TC groups had significantly lower arrest rates but differences in other outcome variables were not significant); however, the most powerful finding was that there was a consistent and significant correlation between treatment outcomes and time in program. The Stay'n Out evaluation research like other TC evaluation research consistently found statistically significant and salient effects between time in program and treatment outcomes. Generally speaking, failure to look at time in treatment is almost always bound to mask important findings and to yield spurious no-difference outcomes.

Male and female Stay'n Out clients do better on parole if they remain in the program for 9 to 12 months rather than terminating earlier (or later). Furthermore, similar lengths of time spent in the comparison modalities do not produce a positive effect. This pattern was found to be consistent for the other outcome variables as well, leading to the firm conclusion that Stay'n Out is more effective than no treatment and alternative treatments, especially so when clients remain in treatment for an optimal period.

When clients who completed the program in 9 to 12 months were compared with clients who left within three months, differences between the percentages positively discharged from parole for the two treatment

periods were significant. Among the males who terminated in less than three months, the percent with favorable outcomes was only 49.2 percent, whereas the counterpart rate for the males who stayed in the program for 9 to 12 months was 77.3 percent. Similar findings were obtained for females, although the percentages with favorable outcomes were generally higher than for their male counterparts (79% for females in treatment less than three months, 92% for the 9 to 12 month group).

For those who failed (i.e., those rearrested or reincarcerated), more time in TC treatment was also related to positive treatment outcomes. When the mean time until arrest was compared for the two termination periods, it was found that clients who received treatment for shorter periods were arrested much sooner than those who stayed in the program for 9 to 12 months. Furthermore, the percent of Stay'n Out male clients who were not reincarcerated after 9 to 12 months of treatment was considerably higher (72% within three years after release from prison) than for males who resigned or were dismissed earlier (60% within three years). Indeed, a logistic regression analysis showed that the odds of not being reincarcerated were nearly three times greater for clients who remained in treatment for 9 to 12 months than for clients who spent less than nine months in treatment adequately controlling for the effects of motivation, deterrence, and treatment.

Clients who received 9 to 12 months of treatment were not only less likely to recidivate than clients who spent less time in treatment, but they also did better than clients who remained in treatment over one year. This finding was consistent for most of the outcome measures tested (time until arrest, positive parole discharge, reincarceration). A multiple regression analysis confirmed a statistically significant decline in time until arrest for

clients who remained in treatment for more than 12 months. *It should be noted, however, that the clients in this group are still significantly less likely to recidivate than those who terminate from the treatment in less than nine months.* We are not certain why this increased risk of failure occurs for those who spend more than 12 months in program, but we believe it is due to two factors: the optimum effectiveness for the in-prison TC is 9 to 12 months; and there is anger and depression generated by not being released on parole after graduating at the end of one year in the program. Having to spend additional time incarcerated before being reconsidered (in the light of the expectation to be released) has negative effects on progress toward rehabilitation. *Thus, the robust central conclusion of the Stay'n Out research is that hard-core drug abusers who remain in the prison-based therapeutic community longer are more likely to succeed than those who leave earlier, and that 9 to 12 months appears to be the optimal duration for the treatment.*

The Cornerstone program is a well respected treatment program for alcohol and drug dependent offenders that began in 1976 and is situated on the grounds of the Oregon State Hospital in Salem, Oregon. It consists of a 32-bed residential unit and a six-month aftercare program. Cornerstone is jointly administrated by the Oregon Divisions of Mental Health and Corrections. Inmates are referred to the program by prison counselors. Admission criteria require that candidates have a history of substance abuse, do not have a history of psychosis or sex offenses, are at least six months but not more than twelve months from their parole, qualify for minimum security, and plan to remain in the state after release. In 1984, Cornerstone clients had an average of about seven felony convictions, had

served over seven years in prison, and all but five percent of the clients had histories of polydrug abuse.

Like Stay'n Out, Cornerstone is modeled on the therapeutic community concept. The conditions that prevail at Cornerstone regarding rules, group participation, earning privileges and so forth are almost the same as in the New York program. The major difference between the two programs is that Cornerstone had, at the time of its evaluation, a six-month aftercare phase in which graduates worked and lived in the community, and few of the staff were recovering persons—i.e., role models.

Two evaluation studies of the Cornerstone program assessed several treatment outcomes, including recidivism (Field 1984, 1989). The findings of both studies are summarized here because they demonstrate the effectiveness of the program over time. The 1984 study evaluated all clients who graduated between 1976 and 1979 against three comparison groups: (1) clients who dropped out in less than one month during the same time-frame; (2) all Oregon parolees (from 1974 to 1977) who had a history of substance abuse; and, (3) a sample of Michigan parolees. There were no statistical differences between the demographic characteristics of the program graduates (N=144) and the dropouts (N=27). The group of Oregon parolees (N=179) had significantly less severe histories of substance abuse and crime than the program graduates. The sample of Michigan offenders (N=217) was based on a population similar in background to the Cornerstone groups.

A three year follow-up study compared the groups according to two outcome measures: the percent not returned to prison and the percent not convicted of any crime. *The program graduates had a significantly higher success rate for both outcome measures than each of the other groups.*

Seventy-one percent of the program graduates were not reincarcerated three years after release; only 26 percent of the dropouts avoided reincarceration. Similarly, while slightly more that half the program graduates were not convicted of any crimes (including minor offenses), less than 15 percent of the dropouts were not convicted of any crimes. As Field points out, the factors that cause residents to drop out may also influence recidivism; however, the favorable comparison with the other two groups supports the hypothesis that treatment in the Cornerstone program is associated with reduced recidivism. Indeed, statistical tests of both outcome measures showed that Cornerstone graduates had significantly better outcomes ($p<.01$) than the Oregon parole sample (63 percent of the parolees were not reincarcerated and only 36 percent were not convicted of any crimes). These univariate statistical differences tend to understate the effect of the treatment because the program graduates had significantly more severe criminal and substance abuse histories.

Field's 1989 study produced similar results, using a different research design. A group of program graduates (N=43) with an average stay of eleven months in treatment was compared with three groups of clients who did not graduate: (1) clients who spent over 6 months in the program (N=43), (2) clients who spent between 2 and 6 months in treatment (N=58), and (3) clients who were in treatment for less than 2 months (N=65). The measures of recidivism that were assessed in the three-year follow-up include: the percent of each group without arrest; without conviction; and, without reincarceration (which included jail terms greater than six months as well as prison sentences).

The results for the program graduates in this sample were quite similar to the findings in the earlier evaluation. Slightly more than half the

graduates were not convicted and about three-quarters were not reincarcerated; in addition, 37 percent were not arrested. These results compared quite favorably to the three groups that did not graduate. For example, 21 percent of the non-graduates who were in treatment for over six months were not arrested, 28 percent of them were not convicted, and 37 percent were not reincarcerated. The findings for the other drop-outs are even more startling. Only eight percent of the clients who dropped out in less than two months were not arrested during the three year follow-up, only 11 percent were not convicted, and only 15 percent were not reincarcerated. These findings are consistent with the findings on the Stay'n Out program, which showed that increased time in program is associated with more positive treatment outcomes.

In addition to comparing the percent in each group that did not recidivate, Field assessed the effect of the treatment on rates of recidivism, that is, the average number of times clients in each group were arrested, convicted, and incarcerated. (These measures imply an expected probability of the number of times offenders will recidivate depending on the amount of time they spend in treatment.) The three-year post-treatment period was compared to two different three-year intervals prior to the prison term that involved treatment in the Cornerstone program. These intervals were the 36 months "at risk" prior to the Cornerstone incarceration and the prior 37 to 73 months "at risk". (The "at risk" intervals represent time in the community; they exclude time spent incarcerated.) Because some subjects were too young to be "at risk" for six years before the Cornerstone incarceration, only about 75 percent of the subjects in each sample were included in this analysis.

The results of the analysis were consistently lower for the program graduates in terms of the percent of each group that did not recidivate (whether measured by arrest rate, conviction rate, or incarceration rate). Furthermore, as the length of time in treatment increased, recidivism rates declined. Perhaps the most interesting findings pertain to the comparisons between the pre-treatment and post-treatment intervals. *Whereas the recidivism rates during both pre-treatment intervals were about the same for each of the groups, recidivism rates during the post-treatment period were considerably lower among the program graduates, and the amount of decline in recidivism rates between the pre-treatment and post-treatment periods was greatest for the program graduates.*

These studies, of the Stay'n Out program and the Cornerstone program, are the first large-scale research evaluations to provide solid evidence that prison-based therapeutic community treatment can produce significant reductions in recidivism rates among chronic drug abusing felons. It is worthwhile noting that the success of this type of holistic treatment is probably due to the fact that it deals with many of the social and psychological impediments to returning to acceptable social functioning that inmates possess. It deals with the myriad problems associated with the lifestyle of addiction as well as the drug use -- and is therefore more likely to be successful in the long run than treatment programs that focus mainly on drug abuse. The cost effectiveness of the treatment makes the case for implementing such programs even more imperative. Programs like Stay'n Out cost about $3000 to $4000 more than the standard correctional cost per inmate per year. Programs like Cornerstone with more professional staff and one-fourth the caseload per staff member cost a little over twice as much for the same time period. The

savings produced in crime-related and drug use-associated costs, however, pay for the cost of the treatment in about two to three years. It is an inescapable conclusion that treatment lowers crime and health costs as well as associated social and criminal justice costs. Moreover, the higher the investment in rehabilitating the most severe offender-addicts, the greater the probable impact. The most serious chronic heroin and cocaine users (about 3 to 10% of all offenders, depending on jurisdiction) are each responsible for a high volume of predatory crime. (Gropper, 1985 based upon the work of Johnson et al., 1985; Ball et al., 1983; and Inciardi, 1979). Any substantial reduction in such criminality among this group immediately has an impact on our quality of life. Without intervention this group will return to crime and drug use nine times out of ten after release, and most will be back in custody within 3 years. With appropriate intervention, more than three out of four will succeed, i.e., reenter the community and lead a socially acceptable life style. This highly predatory group is amenable to long-term (9-12 month) therapeutic community treatment while incarcerated, and is unlikely to benefit much from less intensive treatment.

Two other programs deserve mention in this connection: Wharton Tract and Simon Fraser.

The Wharton Tract Narcotics Treatment program opened in New Jersey in 1970 (and is described in Platt et al. 1980). This program differs from the two previously described TCs in that it is for youthful offenders, but it utilizes a similar treatment model. The program housed 45 youthful offenders (over 19 years of age) in a former state forestry camp situated in Wharton State Forest. The program was a satellite unit of the Youth Reception and Correction Center in Yardville. Youthful offenders were

admitted to the program if they met the following criteria: an 8-12 month period of incarceration remaining; over six months but less than five years of dependency on heroin; no extreme psychopathology; no recent escape; no serious offense pending.

The program was based on the therapeutic community model and included Guided Group Interaction (GGI) in the therapeutic process. (The essence of GGI is that the development of a group in an isolated treatment setting enhances the recovery of its members through a process of intensive guided peer interaction.) In addition, the program included Interpersonal Problem-solving Group Therapy as a technique. Problem-solving skills (e.g., identification of a problem and the feelings associated with it, acquiring information, searching for possible solutions, and assessing consequences) were developed through a series of group exercises. The program also offered couples therapy, family counseling, individual counseling, and recreational activities. Residents completed the program in three phases: a 30-day evaluation period, intensive therapy (lasting at least 60 days), and a transition phase to ease residents back into the community.

An evaluation of the Wharton Tract program compared a group of graduates (N=160) to a control group (N=148) which met all the criteria for admission but did not enter treatment (Platt et al., 1980). There were no significant differences between the background characteristics of the two groups. Based on a two-year follow-up of parole outcomes, the research found that the addict control group had a significantly higher ($p<.05$) recommitment rate (30%) than the program graduate group (18%). Furthermore, the percentage of program graduates that remained arrest-free (51%) was significantly higher than in the control group (34%).

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The Simon Fraser University program provides treatment to prisoners in Vancouver, Canada (see Chaiken, 1989). The Department of Continuing Education administers the Prison Education Program under a contract with the government. The program is housed in trailers and bungalows (with classrooms, offices, a library, and a study area) on the grounds of four institutions. Although funding for the program was initially intended to reduce illiteracy, the goal of the program has broadened to enhance the moral development of offenders through a humanistic approach to education.

Simon Fraser faculty conduct a variety of classes in the liberal arts for student-prisoners who have histories of serious drug abuse and criminal activity. The students are expected to attend lectures and seminars, conduct library research, write papers, and participate in informal discussions of literature, current events, family practices, and publications. Two hundred students attend all-day sessions; they are given time for meals and appointments with medical, psychological, and social service staff. Seven full-time faculty members develop the curriculum and, with the assistance of adjunct faculty, teach courses. The faculty also oversees extracurricular activities and advises the students. There are no security guards assigned to the program, and substance use is not monitored. The program has an open admissions policy, but it requires participation for a minimum of one semester. There is no limit to the time students can stay in the program, and after they are released from prison, they can finish their degrees as regular university students at the Burnaby campus.

In 1980, an evaluation of the program compared a group of 65 former student-inmates to a group of 65 inmates who did not attend the program but were released during the same time-frame (Duguid, 1987). Although the mean age of the two groups were the same, the student-inmates had both a significantly higher percentage convicted of drug offenses and addicted to opiates (56 percent of the students were previously addicts, whereas only 21 percent of the non-students were addicts). The non-students were more likely to have been convicted of burglary than the students. Although 65 percent of the students had not completed high school, their average level of education (10.3 years) was higher than the non-students (8.5 years). A three-year follow-up study found that half the non-students were returned to prison, whereas only 16 percent of the students were reincarcerated.

Project REFORM

Dissemination of these results has already had an important impact on the field and has generated interest as well as funding to support effective treatment for substance abusers while in prison. In 1987, the Bureau of Justice Assistance (BJA) of the federal Department of Justice awarded a grant to Narcotic and Drug Research, Inc. (NDRI), to initiate Project REFORM, to provide technical assistance to state departments of correction to help them plan statewide comprehensive drug abuse treatment for correctional inmates and implement the plans that developed. In the two years that NDRI's Project REFORM has been in operation, eleven state departments of corrections (Alabama, California, Connecticut, Delaware, Florida, Hawaii, New Jersey, New Mexico, New York, Oregon and Washington) have received technical assistance in developing

(or enhancing) their comprehensive prison-based drug abuse treatment systems from NDRI's technical assistance and training team. Before the program ended, we assessed how much programming was implemented by the REFORM states that completed at least *eight* months of implementation (AL, CN, DE, FL, NM, NY and OR). The number of drug abuse treatment system components *operating as a direct consequence* of NDRI's technical assistance at that time were: 39 assessment and referral programs implemented and 33 expanded or improved; 36 drug education programs implemented and 82 expanded or improved; 44 drug abuse resource centers implemented and 27 expanded or improved; 20 in-prison self-help 12-step programs implemented and 62 expanded or improved; 11 urine monitoring programs and 4 expanded or improved; 74 pre-release counseling and/or referral programs implemented and 54 expanded or improved; 39 post-release treatment programs with parole or work release implemented and10 expanded or improved; and, 77 isolated unit (milieu or TC) treatment programs initiated and/or improved including: 16 brief (less than 6 weeks), 19 short-term (6 to 12 weeks), 34 intermediate (5 to 9 months), and 8 long-term (9 to15 months) treatment programs based on the Stay'n Out and Cornerstone models.

As a direct consequence of Project REFORM's work, for example, the New York legislature adopted (in July, 1989) a coordinated approach to treatment in its "Omnibus Prison Bill," emphasizing treatment with Stay'n Out as the model program. It makes an Alcohol and Substance Abuse Treatment Facility of 750 beds and seven 200-bed Substance Abuse Annexes the core of its expansion. These facilities will utilize outside contractors for providing drug treatment for inmates (who are within two years of parole eligibility) and will guarantee participating inmates a slot

in their non-correctional treatment facilities upon release. The bill also provides funds to train up to an additional 300 counselors to be used as part of intensified drug treatment programs. As of the present, however, the substantial fiscal shortfall in New York State is delaying its full implementation.

In June 1990, NDRI conducted a three-day workshop in correctional drug abuse treatment for six more states (Colorado, North Carolina, Virginia, Georgia, Michigan, and Pennsylvania). This workshop was sponsored by the Office of Treatment Improvement (OTI) of the Alcohol and Drug Abuse, and Mental Health Administration (ADAMHA) who has taken over the correctional drug abuse treatment arena from the Bureau of Justice Assistance. [BJA terminated the program asserting that their goal was to stimulate the states to action and let the initial ten states serve as models for the rest of the states using their block grant money. OTI, under the leadership of Dr. Beny Primm, has eagerly picked up the program, and its leader is Nicholas Demos, an unusually dedicated public servant, who ran the Corrections program for BJA.] In April, 1991, OTI awarded an eighteen-month contract to NDRI, in essence, to continue the Project REFORM work—that is, to be the national technical assistance provider. Its new name is Project RECOVERY. Throughout its course, NDRI will be providing technical assistance to the fourteen Project RECOVERY states: Alabama, California, Colorado, Connecticut, Georgia, Hawaii, Michigan, North Carolina, North Dakota, New Mexico, New York, Pennsylvania, Virginia, and Washington. Among the other tasks to be performed are: convening semiannual correctional drug treatment workshops; developing and distributing correctional drug abuse treatment technical assistance materials; publishing a quarterly newsletter on correctional drug

treatment; developing a handbook on planning, implementing and maintaining prison drug treatment; and coordinating correctional treatment projects with national drug treatment and correctional organizations.

I and my colleague, Dr. Harry Wexler, have learned several lessons from this experience. First, the states are very interested in doing rehabilitation. Among correctional administrators there is an interest that has been lying dormant for about 15 years; and from recent surveys (Cullen, Clark and Wozniak 1985; Skovron et al, 1988) there is a strong attitude on the part of the public in support of rehabilitation as opposed to incapacitation and punishment. It is significant to note, Mr. Chairman, that there were many more applicants for BJA's Project REFORM program than could be afforded, and far more than the OTI effort could support. It is apparent, moreover, that the seed money provided by the BJA in the original REFORM effort was catalytic in stimulating the interest of the states, and sufficient to generate state revenues far in excess of the Federal investment. The federal (BJA) portion amounted to about $500,000 per state for both planning and implementation. The states in consequence, without being required to, have appropriated about four to ten times that much out of their tax levy monies to make the programs happen. For this Federal investment of about $5 million, a great deal of programming was generated. Our current examination of the program's accomplishments reveals that most states have expended or pledged far more funds, staff and programming for drug abuse treatment in corrections than had been foreseen when plans were drawn. The effort has for the most part been quite catalytic in generating development in this needful area. The OTI's

current commitment of $4 million for this purpose will allow the mission to continue, but at a very slow pace.

The proposed legislation, HR 730 does in large measure speak to the national need. I heartily endorse the intent of the bill and the dollar amounts proposed. Given the vast numbers of incarcerated drug abusers, however, it will only begin the process of bringing these predatory persons to recovery. Nonetheless, by concentrating on these offender-addicts, the effort will undoubtedly be quite cost effective—a salient factor to the public's view. It is my hope that my testimony today will encourage this Committee's consideration of expanding this program to provide funds to stimulate planning and implementation for correctional drug abuse treatment to all the states following the BJA model that has been so successful. I have only two concerns regarding this bill, HR 730. In Section 577.b.4.a. I would recommend altering the urinalysis requirement as follows: 3x/wk—first month; 2x/wk—second month; 1x/wk—third month; 2x/month—months four to nine; 1x/month—last three months. For each dirty urine, the releasee is set back to the previous schedule. I would also recommend adding a requirement for evaluation research allocating $500,000 per year to measure the process, implementation and outcome of the efforts undertaken by the states under this legislation.

Community Care and Continuity of Treatment

Programs that begin within the prison's wall must continue into the community after the inmates release, and they should continue for the length of time that the criminal justice system has custody. Changing a drug abuser's lifestyle is a difficult and time-consuming process. The

experience of reentry after treatment for an offender is even more difficult because of all the temptations and triggers to relapse (conditioned cues) that are encountered upon returning to where one used drugs. It is essential therefore to strengthen paroling authorities with program referral and direct service options for former drug abusers being released on parole. Self-help groups for recovering persons generally appears to be an important element in forestalling relapse. Participation in self-help groups such as Narcotics Anonymous and Cocaine Anonymous appears to be positive, if not essential, but unfortunately there is little empirical evidence to support the claims of these organizations. Moreover, former drug abusing offenders who have sought to participate in some Alcoholics Anonymous chapters have not been warmly accepted, and success claims for AA cannot be verified. In some states, these organizations are the only substance abuse aftercare treatment entities for the ex-offender.

As I noted earlier, Mr. Chairman, I am a researcher. It would be unseemly, then, if I did not recommend that research be funded in this important area. I see the need in three arenas. First, there are few studies reporting the outcome of drug abuse intervention and treatment programs for institutionalized youths who were drug abusers before arrest or who were at high risk for becoming abusers; nor do we know the extent of the need for treatment within this population, but we suspect that it is high. There is also a need for studies to evaluate such programs for incarcerated women (Stay'n Out is the only one so far). Second, much of the information we assembled during the seventies and eighties came from studies with heroin users. The vast number of persons being incarcerated today are cocaine abusers, particularly abusers of crack. We need to know much more than we do about the treatment of crack/cocaine, and whether the

treatments that were developed during earlier periods still have validity for criminally-involved crack users. Third, there is a need for studies of innovative techniques (e.g., hair analyses, sputum analyses, electronic monitoring) for monitoring the criminally-involved drug user for surveillance, clinical and research purposes. With better techniques we can assure the safety of the community while treating persons in the community where it is less costly, and we can release persons earlier relieving prison overcrowding.

There are many drug-using offenders who could benefit from being diverted from incarceration, and who would not, under appropriate levels of supervision, present a serious risk to the community. A successful vehicle for this is the Treatment Alternatives to Street Crime (TASC) program. TASC provides case management for drug-abusing defendants and offenders acting as a bridge between criminal justice agencies (courts and probation) and treatment providers. At the current time there are 173 TASC projects around the country providing screening, assessment, treatment planning, monitoring, urinalysis and court liaison functions. The concept of TASC emerged from research showing treatment is more effective in settings where legal sanctions and close supervision provide incentives for clients to conform with treatment program protocols and objectives. Longer treatment duration is consistently associated with better treatment outcome, and clients under legal coercion generally stay in treatment longer than clients not under legal coercion. TASC clients remain in treatment six to seven weeks longer than other criminal justice clients whether referred to residential or outpatient programs. If TASC or TASC-like programs were available in more cities around the country, many more persons, particularly young ones, could be diverted to treatment.

Unfortunately, with recent upward trends in drug-related crimes, the demand for treatment programs is far greater than the treatment system can provide. Thus, not only must we have more programs for offenders who are incarcerated, but a great deal more for those on probation or in other community supervision statuses.

Another point I wish to emphasize, Mr Chairman, is the need to include a wide variety of services to meet the needs of the imprisoned population. These persons, largely from minority groups and from well-below-average income backgrounds, lack social and vocational skills, lack literacy and numeracy, and suffer from a variety of psychological and psychiatric ills. They function poorly without remediation of these problems, but respond well to "habilitation" programs that provide these components. My 28 years of experience in this field and my own and my colleague, Harry K. Wexler's research leads me to believe (a belief also shared by many treatment professionals in the drug abuse treatment field) that offenders' addictions cannot be treated in isolation from their medical, psychological, social and practical deficits. Programs that are initiated must deal with inadequate communication skills, inadequate understanding of human relationships and responsibility, insufficient maturity level, and inadequate job skills among other things. Habilitation programs such as Stay'n Out and Cornerstone deal very well with many of these deficiencies but they still lack the breadth of service programming necessary to help many persons. The men who failed in Stay'n Out, for instance, in most cases failed for vocationally-related reasons. The success of programs like Stay'n Out, however, can be enhanced and sustained with a thoughtfully coordinated continuum of therapeutic services and this is strongly warranted for criminal justice populations.

Conclusion

There are persons in senior policy making positions as well as academia who could not agree that rehabilitation is or should be one of the key purposes of the post adjudicatory system. If it comes down to a matter of opinion whether the state has a responsibility to undertake correctional rehabilitation, I will firmly declare for it. The empirical evidence unquestionably supports its utility. I assert that the federal government and the states have both a responsibility to encourage and sponsor rehabilitation for addict-offenders, and a significant opportunity to do so. Three balanced purposes can and should be effectively and simultaneously served: (1) punishment (individual deterrence); (2) direct preventive force (incapacitation); and (3) retention for prosocial change (rehabilitation).

In summary, I believe that just serving time inexorably degenerates both inmates and their keepers. I believe that we should use time as an opportunity for change. It values both of them, and eventually alters the quality of life for all of us. Thank you for the opportunity to share these insights and thoughts with you. This concludes my testimony. I will be pleased to answer any questions the Committee may have.

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TESTIMONY PRESENTED TO THE

U. S. HOUSE OF REPRESENTATIVES

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

Congressman Charles B. Rangel, Chairman

May 14, 1991

Morris L. Thigpen, Commissioner
Alabama Department of Corrections
Montgomery, Alabama

PRISON SUBSTANCE ABUSE TREATMENT PROGRAMS WITHIN THE ALABAMA DEPARTMENT OF CORRECTIONS

Morris L. Thigpen
Commissioner

Extent and Severity of Drug Addiction Among Inmates

Approximately two years ago, a decision was made within the Alabama Department of Corrections to include substance abuse histories and the assessment of substance abuse treatment needs as a part of the intake process for each of the almost 6,000 inmates we take into our system each year. This information has consistently shown that approximately 80 percent of the inmates processed into our system have significant substance abuse histories. Of that figure, approximately 50 percent admitted to or were assessed as addicted to a mind-altering substance; and 20 percent admitted to histories of frequent intravenous drug use.

Cocaine and crack cocaine are the most frequently abused drugs, followed by alcohol with marijuana as a close third. A large variety of other drugs were also reported to be used by a small percentage of the inmates. Our data appears to be consistent with the results from Birmingham, Alabama, of the Drug Use Forecasting Project conducted by the Bureau of Justice. Results showed that approximately 75 percent of those persons arrested for felony violations tested positive to illegal drug use at the time of the arrest. Approximately 50 percent of this group tested positive for cocaine. The responses of the inmates in our treatment programs give us additional confidence in our data; however, these responses add a very disturbing dimension with repeated testimony of patterns of illegal activities to support their drug habits. Inmates very often describe regular routines of burglaries, shoplifting, trafficking stolen goods, dealing drugs, and other violent crimes to support these drug habits.

The number of inmates sentenced to state correctional facilities is steadily rising. That fact, coupled with long sentences in an attempt to stem the increase in crime, resulted in a net increase in our population of approximately 1,500 annually. We recently passed the 16,000 mark and most likely will pass 17,000 by the end of this year. In 1975, the Department of Corrections received 5.6 percent of the General Fund appropriation in Alabama. By 1990, that figure had increased to 16.7 percent. Recent studies show that approximately one-third of the inmates

received into the Department of Corrections are parole or probation revocationers; and a large percentage of these are directly related to substance abuse and addiction. A recent in-house study revealed that 63 percent of failures in community based programs, i.e. pre-discretionary leave and Supervised Intensive Restitution program, were due to drug use or related charges. A follow-up to this study which covers the second quarter of FY 90-91 showed similar results with 58 percent being returned for cocaine use. Data readily available to me reveals that substance abuse addiction is overcrowding our prisons, straining the state budget, and plaguing our citizens with crime.

Alabama Department of Correction's Response to Drug Problem

My reaction to these findings was to launch a concerted effort in the "War On Drugs" in the correctional institutions since it was abundantly clear that the very heart of the hard-core drug problem is squarely within the walls of our prisons. Last year Senator Biden's committee reported that one-half of the nation's estimated 2.2 million cocaine addicts transient the criminal justice system every year which certainly reflects the data that I review. This suggests that we could offer treatment services to a large percentage of cocaine addicts as they move through the criminal justice system if such programs were present.

We have a high degree of control over the inmate population which is a useful advantage in the drug treatment process. Although prisons may not be the ideal location for drug treatment, the reality is that literally thousands of inmates are in need of treatment services. Therefore, I fail to understand why such a small portion of the funds dedicated to the "War On Drugs" is available to correctional administrators. Until three years ago, the Alabama Department of Corrections was not even considered for a portion of the federal grant dollars to promote the "War On Drugs." Even at the present time, the large pockets of funds are not shared with corrections since we are not perceived as playing a vital role in this effort. We most likely will not be perceived as key players unless action is taken to earmark funds proportionately to the existing drug problems.

Records show that of approximately 4,000 addicted felons, 2,000 are awaiting some form of substance abuse treatment. With the aid of the Bureau of Justice Assistance discretionary and block fund grant monies, we have been able to open approximately 900 drug treatment beds. However, the waiting lists simply do not shrink since we continue to receive approximately 3,000 inmates a year who need substance abuse treatment with more than 75 percent of that number volunteering for treatment.

A large number of incarcerated addicts who request treatment can be explained in part by the degree to which we reward those inmates who make gestures toward recovering lifestyles. Prisons are a relatively closed society where drug searches and drug testing can be performed without the restrictions experienced by other segments of society. Our clients do not leave their families or disrupt their jobs to go to a treatment center. Of course, there is less social stigma in prison resulting from admitting addiction as compared to that as experienced by free-world citizens.

Prisons can offer a cost efficient place for drug treatment. Our very popular 8-week inpatient program costs $400-500 per client in addition to the already obligated cost of incarceration. A 28-day free world program would require the citizen to take a month off from his/her job and face a fee of $10-14 thousand. A side benefit that we have found is that our dormitories devoted to drug treatment quickly become the quietest, the cleanest, and the most disciplined units in the prisons. Our experience gives new meaning to the old phrase that good treatment is good security.

I would like to now describe the programs currently in existence in Alabama. Six of our fourteen major institutions have at least one dormitory devoted exclusively to inpatient substance abuse treatment. 75 percent of the necessary funding is available with BJA Block Grant funds. Our most recent and probably the most exciting venture was opening our newest facility, the Ventress Correctional Facility in Clayton, Alabama, as a 600-bed treatment facility with the primary mission of providing some form of drug treatment to every inmate housed there. This project was initially funded by an $841,000 grant from the Office of Treatment Improvement of the Bureau of Justice.

Two of our institutions, one of which is maximum security, have a dormitory that has been transformed into a Therapeutic Drug Treatment Community (TC). The TC is a one-year drug treatment effort that has produced spectacular results. Numerous visitors, including Dr. William Bennett, former Drug Czar, have praised this remarkable effort. This highly structured program encompasses the "community" concept patterned after the Phoenix House Therapeutic Communities. Major emphasis is on confronting negative behaviors and teaching "right living." Skilled staff needed to implement this highly sophisticated drug program are difficult to find. The idea is still somewhat radical so that growth of these programs has been slow. Although we are sold on the concept, we only have 150 operational beds in this modality. Today 498 beds are devoted to our 8-week inpatient

program which is based on the Twelve Steps of Alcoholics Anonymous and Narcotics Anonymous and patterned largely after the traditional inpatient drug treatment centers operated in the free world. Approval of our pending grant renewal request for BJA Block Grant funds would increase participating inmates by approximately 20 percent. This increase will include an inpatient drug treatment program in our HIV living unit at the Limestone Correctional Facility. Additionally, we have small inpatient programs available at two work release centers for inmates who have tested positive for drugs, but we believe that security considerations will permit these inmates to return to community based programs upon successful completion of drug treatment.

We have developed continuing recovery (after-care) programs in two institutions -- 240 beds at the Ventress facility which is the prison devoted exclusively to drug treatment and 20 beds at our female work release center. In these programs, we endeavor to structure the ideal components of a recovery lifestyle which all treatment centers would want their clients to practice upon release.

The Alabama Department of Corrections is quickly becoming the largest provider of inpatient drug treatment in the state. Although data is not available, we believe that we are rapidly approaching the total number of inpatient drug treatment beds of all other providers in the state. It is too early to have any long term data on the effectiveness of our interventions; however, we are carefully recording all entries into and exits from treatment for long term research. Informal studies and other indicators show great promise. As an example, we have learned that inmates who have completed drug treatment in prison and then released are prominently represented in 12 Step Groups throughout the state. In many cases, these inmates have assumed leadership roles.

A vital component of any drug treatment effort is drug testing. Not only are inmates randomly tested; correctional officers are tested, also. As a result, several officers have been removed due to positive test results. Drug testing has proven to be a very valuable tool in exposing the need and in motivating the inmates to apply for treatment. It also adds credibility to the treatment effort when inmates are drug tested on a regular basis both during and after treatment. We currently operate eight drug testing "laboratories" inside selected facilities which yield more than 10,000 results monthly. The number of inmates is a product of dividing the number of drugs tested for into the total number of results. For example, if every inmate were tested for cocaine, heroin, and marijuana, then approximately 3,500 individuals would be tested that month. These testing sites are also

grant funded. Automated drug testing machines operated by correctional officers produce results for little more than $1.00 per result. Each machine has the capacity to produce one test result per minute. Drug testing in the Alabama Department of Corrections cost $140,000 over the past 12 months. 75 percent of this funding was secured through a Bureau of Justice Block Grant administered by the state. Federal restrictions will only permit funding of that program for one more year. If limited state funds are not available, it may be necessary to reduce the program.

Goals for Future Efforts and How the Federal Government Can Help

Our relatively short history with drug treatment has led us to adopt the goal of providing drug treatment to every inmate that needs it and who is willing to accept such treatment. The program pioneered in Alabama of converting an entire prison to a drug treatment center is the most likely avenue to realistically meet this goal. Within the next month, we will select the site for a new prison that is required to take care of a portion of the monthly growth we are experiencing. There is already active discussion within my staff to design this facility as a drug treatment center. Many cost cutting measures and compromises are necessary just to get this prison constructed without our facing the task of securing funding for furnishings, staffing, and operations. I hope that I have persuaded you that this is an ideal place for federal funds to provide drug treatment to 1,000-1,500 addicted Alabama citizens each year.

Other areas are in need of state and federal support. Aftercare in the community for the drug offender needs expansion. Convicted felons returning to the community are not viewed as desirable clients by many community treatment and aftercare providers. It may be necessary to earmark federal funds supporting these programs in order to secure services for ex-inmates.

State funds for researching the effectiveness of prison treatment programs are difficult to obtain. Federal funds are needed and are necessary in this area. We are currently seeking additional federal funding to establish long range drug treatment research projects designed to evaluate our existing drug treatment programs. Our proposal includes taking inmates completing one of our drug treatment programs and housing them in drug-free environments within our facilities so the inmates can practice the recovery skills learned during treatment. These inmates will work, go to school, or participate in programs available to other inmates but would begin their day in the tradition of the recovering addict with the morning meditation, self-help groups, a recovery journal, and supporting each other. In turn, we would attempt to reward these recovering inmates with more wholesome living environments and perhaps even enhanced amenities. Family

programs could be incorporated into the regular visiting programs, recovery libraries could be a part of each of these dormitories and could serve as a training site for recovering individuals desiring to enter the drug treatment field.

We are beginning to explore the concept of providing drug-free dormitories to those inmates who have completed treatment in all of our institutions. Hopefully, this will redefine the inmate culture in these units and will further provide the valuable service of separating those inmates willing to make the commitment to live without illegal drugs from those inmates who are not willing to make such a commitment. This information should be exceptionally valuable to parole officials, judges, and other segments of the criminal justice system.

The enlightened correctional administrator no longer leaves the control of prison to the inmates. He no longer accepts what has been heard for years of prisons being universities for crime or that you can find drugs as easily in prison as on the streets. Most believe also that although prisons may not be the most desirable place for drug treatment, it can successfully take place there. In a White Paper published in June, 1990, entitled "Understanding Drug Treatment," Dr. William J. Bennett stated, in part, "...The ethos of personal accountability and adherence to rules that pervades the criminal justice system is frequently a part of effective drug treatment. Good treatment programs insist on a code of conduct, individual responsibility, personal sacrifice, and sanctions for misbehavior. There is now an impressive amount of evidence to suggest that when drug treatment contains these elements, we get results: addicts change their self-destructive pattern of behavior and stop or dramatically reduce drug use. That's why drug treatment and criminal justice must be understood as allies in our fight against drug use." Drug treatment is working in the Alabama Department of Corrections. Daily I receive letters from inmates, their family members, and their friends who are thankful for the drug treatment programs.

Alabama's state motto is "**ALABAMA - LAND OF SURPRISES**" and I hope that we have surprised you with the comprehensive approaches to the "War On Drugs" present in the Alabama Department of Corrections. We clearly need continued federal support that is specifically channeled into corrections in order to achieve our full potential.

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TESTIMONY
OF
KEMI MORTEN,
VICE PRESIDENT AND GENERAL COUNSEL
UNFOLDMENT, INC.

BEFORE
THE U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

ON

DRUG TREATMENT IN PRISONS

MAY 14, 1991

GOOD MORNING DISTINGUISHED MEMBERS OF THE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL. I WOULD LIKE TO THANK YOU FOR INVITING ME TO TESTIFY THIS MORNING. ON BEHALF OF OUR BOARD OF DIRECTORS, I AM HERE TODAY TO EXPRESS UNFOLDMENT'S FULL SUPPORT FOR THE SPEEDY ENACTMENT OF H.R. 548 AND 730.

UNFOLDMENT, INC. WAS FOUNDED IN 1977, BY MY FATHER BAKER E. MORTEN, A VETERAN JOURNALIST, PRIMARILY TO HEAL CRIMINAL IMPULSES AMONG TROUBLED DISTRICT YOUTH. FOR THE LAST 14 YEARS, WE HAVE ASSISTED MORE THAN 5,000 YOUTH, PRIMARILY IN THE SOUTHEAST, WASHINGTON PUBLIC HOUSING COMMUNITY OF BARRY FARMS, IN THE AREAS OF READING AND MATH ENRICHMENT AND DRUG EDUCATION AND PREVENTION.

ORIGINALLY, WE HAD NO THOUGHT OF PROVIDING DRUG TREATMENT SERVICES TO LORTON INMATES.

HOWEVER, IN 1989, WE WERE CONTACTED BY MEMBERS OF THE TWELVE JOHN DOES INMATE MISSION, A GROUP OF LORTON INMATES WHO, WITH THE HELP OF COVINGTON AND BURLING, FILED A SUCCESSFUL SUIT AGAINST THE D.C. DEPARTMENT OF CORRECTIONS TO IMPROVE CONDITIONS AT THE PRISON. BY THIS TIME FINES HAD MOUNTED TO MILLIONS OF DOLLARS FOR FAILURE BY D.C. CORRECTIONS TO CORRECT THESE CONDITIONS.

INSTEAD OF FUNNELING THE FINES BACK TO THE DISTRICT GOVERNMENT, U.S. DISTRICT COURT JUDGE JUNE L. GREEN, THROUGH HER SPECIAL OFFICER, THE LATE JUDGE JOHN D. FAUNTLEORY ASKED THE INMATE MISSION HOW IT WISHED TO SPEND THE MONEY. THE MEN REQUESTED THE CREATION OF TWO PROGRAMS -- AN INTENSIVE SUBSTANCE ABUSE TREATMENT PROGRAM AND A VOCATIONAL TRAINING PROGRAM. TO PROVIDE JOB TRAINING, THE INMATES SELECTED THE LIBERATION OF EX-OFFENDERS THROUGH EMPLOYMENT OPPORTUNITIES (LEEO) AND UNFOLDMENT WAS ASKED TO DEVELOP AND OPERATE THE DISTRICT'S LARGEST RESIDENTIAL THERAPEUTIC PRISON-BASED DRUG TREATMENT PROGRAM.

WE HAVE BEEN BLESSED BY VISITS AND SUPPORT FROM EXPERT CRIMINAL JUSTICE PROFESSIONALS DURING THE PAST 16 MONTHS. THESE SUPPORTERS HAVE CALLED OUR PROGRAM A SUCCESS AND A NATIONAL MODEL.

SUCCESS IN THIS FIELD DOES NOT COME EASY AND IT REQUIRES A LOT OF HARD WORK BY MANY, MANY PEOPLE. WE COULD NOT HAVE DONE IT ALONE.

FIRST OF ALL, I WANT TO GIVE CREDIT TO THE TWELVE JOHN DOES PLAINTIFFS WHO RECOGNIZED THAT 85 PERCENT OF ALL D.C. INMATES HAVE SUBSTANCE ABUSE HISTORIES, 60 PERCENT ARE UNEMPLOYED AT THE TIME OF THEIR ARREST AND OF THE EMPLOYED, 30 PERCENT HELD JOBS IN UNSKILLED, LOW-PAID POSITIONS. WITH NO INTENSIVE RESIDENTIAL DRUG TREATMENT PROGRAM AVAILABLE AT THE TIME, THE PLAINTIFFS ASKED FOR AND RECEIVED FUNDS FROM THE COURT FOR OUR MUCH NEEDED PROGRAM.

SECOND, WE WOULD LIKE TO THANK THE LAW FIRM OF COVINGTON AND BURLING, WHICH HAS REPRESENTED THE INMATES SINCE 1980 FREE OF CHARGE AND CREATED NEW LAW IN THE AREA OF PRISON REFORM.

AND THE OFFICE OF THE MAYOR AND COUNCIL OF THE DISTRICT OF COLUMBIA FOR PROVIDING THE FISCAL RESOURCES TO CONTINUE OUR PROGRAM ONCE THE COURT-ORDERED MONIES WERE EXHAUSTED.

I WOULD BE REMISS IF I DID NOT COMMEND D.C. COUNCILMEMBER AND JUDICIARY COMMITTEE CHAIRPERSON WILHELMINA ROLARK FOR HER TIRELESS EFFORTS TO IMPROVE OUR CRIMINAL JUSTICE SYSTEM.

WE WOULD LIKE TO THANK THE D.C. DEPARTMENT OF CORRECTIONS STAFF, UNDER THE OUTSTANDING LEADERSHIP OF DIRECTOR WALTER B. RIDLEY AND CENTRAL FACILITY ADMINISTRATOR JAMES BRAGG.

MOST IMPORTANTLY, MY THANKS TO THE D.C. COMMUNITY FOR WORKING WITH UNFOLDMENT TO WELCOME THESE MEN HOME AND FOR BEING WILLING TO GIVE THEM ANOTHER CHANCE TO HELP THEMSELVES.

CAREFUL PLANNING WENT INTO THE THREE-MONTH DEVELOPMENT PHASE OF OUR PROGRAM WHICH INCLUDED TRAVELLING TO UPSTATE NEW YORK TO STUDY THE MT. MCGREGOR PRISON PROGRAM, WHICH WAS STARTED BY FATHER PETER YOUNG AND FOCUSES ON THE CONCEPT OF RESPONSIBILITY WITHOUT AUTHORITY.

FROM THERE, UNFOLDMENT'S DEVELOPMENT TEAM OF TREATMENT AND CLINICAL PROFESSIONALS CREATED A HOLISTIC PROGRAM WITH SEVERAL ESSENTIAL TREATMENT COMPONENTS.

FIRST, **WE GIVE PREFERENCE IN HIRING TO RECOVERING ADDICTS AND FORMER PRISONERS, WHO HAVE BEEN CLEAN FOR A MINIMUM OF THREE YEARS.** OUR PROGRAM IS BASED ON THE 12-STEP PHILOSOPHY OF NARCOTICS AND ALCOHOLICS ANONYMOUS, AND WE IMMEDIATELY LINKED WITH COMMUNITY-BASED NA AND AA FELLOWSHIPS TO PROVIDE A FREE COMMUNITY-BASED NETWORK OF SUPPORT FOR THE MEN UPON THEIR RELEASE.

SECOND, WE EMPHASIZE THAT OUR PARTICIPANTS TAKE **"RESPONSIBILITY WITHOUT AUTHORITY."** THIS CONCEPT OF EMPOWERING PEOPLE TO MAKE DECISIONS AND TAKE RESPONSIBILITY FOR THEIR ACTIONS CONTRIBUTES GREATLY TO OUR SUCCESS.

WE REFER TO OURSELVES, STAFF AND PARTICIPANTS AS A FAMILY. THE UNFOLDMENT FAMILY CONCEPT CREATES AN ATMOSPHERE OF TRUST AND RESPECT WITH NO BIG I'S OR LITTLE YOU'S.

THE KEY TO OUR SUCCESS IS SIMPLE. HAVING ESTABLISHED A "**FAMILY CONCEPT**," USING RECOVERING ADDICTS AND FORMER PRISONERS AS POWERS OF EXAMPLE, WE PROVIDE THE NECESSARY TOOLS FOR THE MEN THEMSELVES TO MAKE POSITIVE LIFE TRANSFORMATIONS.

OUR FAMILY THERAPY COMPONENT ENCOURAGES THE MEN TO MAKE AMENDS WITH THEIR BIOLOGICAL FAMILIES FOR THE PAIN THAT HAS RESULTED FROM ADDICTION AND INCARCERATION. WE FURTHER COUNSEL BIOLOGICAL FAMILY MEMBERS ON THE DISEASE CONCEPT OF ADDICTION TO RESTORE FAMILY TRUST AND SUPPORT FOR THE INDIVIDUAL UPON HIS RELEASE.

EDUCATION, AS WE ALL KNOW, IS KEY. WITH 50 PERCENT OF D.C. PRISONERS HAVING NOT COMPLETED HIGH SCHOOL, WE REQUIRE OUR PARTICIPANTS TO ENROLL IN A "**DAILY STRUCTURE OF EDUCATIONAL/VOCATIONAL COURSES.**" WE SUPPLEMENT THIS WITH A CULTURALLY RELEVANT CURRICULUM OF AIDS EDUCATION, NUTRITION, PSYCHOPHARMACOLOGY, MORALS AND VALUES, FINANCIAL MANAGEMENT, PSYCHODRAMA, RELAPSE PREVENTION, INTENSE GROUP THERAPY AND INDIVIDUAL COUNSELING.

UNFOLDMENT DESIGNED "**SIMPLE ADMISSION CRITERIA**" REQUIRING FIRST, THAT AN INMATE ACKNOWLEDGE HIS DISEASE AND BE WILLING TO HEAL HIMSELF. SECOND, THE INMATE MUST BE WITHIN 5 YEARS OF PAROLE ELIGIBILITY. THIRD, THE INMATE MUST BE WILLING TO UNDERGO 90 DAYS OF ISOLATION AND FOREGO ALL COMMUNICATION WITH THE PUBLIC AND GENERAL INMATE POPULATION INCLUDING NO RADIO, TELEVISION OR TELEPHONES. WE COUPLED THAT WITH AN EXHAUSTIVE SURVEY AND EVALUATION PROCEDURE TO DETERMINE TRUE WILLINGNESS ON THE PART OF EACH APPLICANT.

WHILE WE REQUIRE A "**90-DAY ISOLATION PERIOD**," WE FEEL THAT AT SOME POINT PROGRAM PARTICIPANTS SHOULD INTERMINGLE WITH THE GENERAL POPULATION TO TAKE ADVANTAGE OF EDUCATIONAL AND VOCATIONAL OPPORTUNITIES AND TO TEST THE STRENGTH OF THEIR RECOVERY.

OUR PROGRAM IS BASED ON A **TRADITIONAL THERAPEUTIC COMMUNITY** CONCEPT WHERE PARTICIPANTS ACTUALLY RUN THE DAY TO DAY OPERATIONS UNDER THE DIRECTION OF UNFOLDMENT PROFESSIONALS.

WE BELIEVE THIS APPROACH IS FAR **MORE COST EFFECTIVE** THAN THE MEDICAL APPROACH OF DOCTORS, PSYCHIATRISTS, AND COSTLY PROFESSIONAL MANAGERS. INSTEAD, WHEN SUCH MEDICAL NEEDS ARISE, WE HIRE THESE SERVICES ON A CONSULTANT BASIS AND UTILIZE EXISTING DEPARTMENT RESOURCES.

WE PRACTICE **MANDATORY CONFLICT RESOLUTION** AT UNFOLDMENT, TO TEACH THE MEN CREATIVE, NON-VIOLENT, PRODUCTIVE WAYS OF COPING WITH ANXIETY AND DIFFERENCES OF OPINION. FOR EXAMPLE WE USE THE PULL-UP, QUIET ROOM AND CONCERN NIGHT TECHNIQUES.

WITH THE ESSENTIAL COMPONENTS DEVELOPED, WE OPENED OUR DOORS ON MARCH 1, 1990.

ON THAT DAY, IN THE MIDDLE OF A DIRTY, DILAPIDATED WAREHOUSE AT THE CENTRAL FACILITY, THE FIRST CLASS OF UNFOLDMENT PARTICIPANTS GATHERED IN WONDER OF WHAT WAS TO COME.

ACCOMPANIED BY BUNDLES OF THEIR WORLDLY POSSESSIONS, THE MEN INQUIRED ABOUT THE STATE OF THEIR NEW HOME. THEY WERE LITERALLY SHOCKED WHEN I ASKED THEM TO FORM COMMITTEES AND PROVIDE ME WITH RECOMMENDATIONS ON HOW TO TURN THE BUILDING INTO WHAT IS NOW A CLEAN, EFFICIENTLY-RUN DORMITORY CALLED T-25. CHALLENGING THESE MEN TO THINK FOR THEMSELVES AND MAKE DECISIONS WAS A TURNING POINT FOR MANY OF THEM WHO HAD FOR SO MANY YEARS BEEN TOLD WHAT TO DO, WHEN TO DO IT AND HOW.

THE RESIDENTS TRANSFORMED T-25 INTO THE CLEANEST, MOST QUIET DORM AT THE D.C. CORRECTIONAL COMPLEX. THEY QUICKLY LEARNED RESPONSIBILITY WITHOUT AUTHORITY -- AND WE LEARNED A LOT TOO.

WE LEARNED, AS WE PROGRESSED WITH THE PROGRAM'S 90-DAY INTENSIVE ORIENTATION PHASE OF TOTAL ISOLATION, THAT THERE ARE A HOST OF ISSUES DEEPER THAN SUBSTANCE ABUSE THAT MUST BE ADDRESSED BEFORE TREATMENT CAN BE SUCCESSFUL.

"LIFESTYLE ADDICTION" IS A REALITY FOR THE MEN. WHAT IS LIFESTYLE ADDICTION? AT UNFOLDMENT WE CALL IT AN ADDICTION TO INSTANT GRATIFICATION OF AN UNREALISTIC DESIRE FOR MATERIAL THINGS WITH NO LEGITIMATE PLAN OR MEANS FOR EARNING THEM. IN OTHER WORDS, AS WE TELL THE MEN, "YOU WANT IT WHEN YOU WANT IT."

WE COUNTER THE CRIPPLING EFFECTS OF LIFESTYLE ADDICTION THROUGH OUR STAFF OF RECOVERING ADDICTS WHO SERVE AS POWERS OF EXAMPLE TO SHOW THE MEN HOW TO SLOW DOWN, LISTEN TO SOMEONE ELSE AND ACHIEVE THEIR LONG AND SHORT-TERM GOALS AT A REALISTIC PACE AFTER CAREFUL PREPARATION.

WE ALSO LEARNED QUICKLY THAT WE HAD TO CONFRONT A PHENOMENON THAT WE CALL **"INSTITUTIONALIZATION."** INSTITUTIONALIZATION RESULTS FROM THE DESTRUCTIVE BEHAVIORS AND ATTITUDES THAT DEVELOP FROM ONE'S CONSTANT EXPOSURE TO PRISON, OTHER PUBLIC INSTITUTIONS AND DYSFUNCTIONAL FAMILIES. INSTITUTIONALIZATION STRIPS ONE OF THE ABILITY TO LIVE THE NORMAL "SQUARE" EXISTENCE OF HAVING TO GET UP IN THE MORNING AND GO TO WORK OR AS WE SAY, THE ABILITY TO "LIVE LIFE ON LIFE'S TERMS.

INSTEAD, CORRECTIONS UNWITTINGLY FULFILLS A MISGUIDED PARENTAL ROLE BY NOT REQUIRING INMATES TO PROGRAM WHILE IN PRISON, AND ALLOWING THEM TO SLEEP AND WATCH TV ALL DAY. CORRECTIONS THEN CREATES UTTER DEPENDENCY IN THIS PARENTAL ROLE BY PROVIDING FOOD, SHELTER, CLOTHING, AND MEDICAL CARE. IN THE FINAL ANALYSIS, JUST LIKE A SPOILED, IRRESPONSIBLE AND DEPENDENT CHILD, INMATES ARE RELEASED BACK INTO SOCIETY AS SOCIALLY DISABLED.

THIS IS NOT BY DESIGN. WE ALL ARE WELL INTENTIONED. HOWEVER, BECAUSE THE DISEASE OF ADDICTION IS A DEPENDENCY IN AND OF ITSELF, AND THE SYSTEM OF INSTITUTIONALIZATION REINFORCES THAT DEPENDENCY, WHEN A PERSON IS RELEASED FROM PRISON, WITHOUT ANY INTERVENTION, HIS ULTIMATE RETURN TO PRISON IS INEVITABLE.

WE HAVE MEN IN OUR PROGRAM WHO HAVE BEEN CONFINED IN JUVENILE AND ADULT CRIMINAL JUSTICE SYSTEMS FOR AS MUCH AS 70 PERCENT OF THEIR LIVES. PRISON LIFE IS EXTREMELY UNNATURAL. AT UNFOLDMENT WE WORK WITH CLIENTS AS COLLEAGUES OR CO-INVESTIGATORS IN PLANNING AND DEVELOPING A LIFESTYLE CHANGE PROGRAM THAT IS TAILOR-MADE FOR THE CLIENT.

ONE OF OUR PARTICIPANTS, WHO HAS BEEN INCARCERATED FOR 18 YEARS, DESCRIBED DOING HIS TIME AS A CONSTANT EXPERIENCE OF PAIN THAT HE COULD NOT ADDRESS BECAUSE OF THE IMAGES HE HAD TO PORTRAY IN ORDER TO SURVIVE IN PRISON. INSTEAD HE MEDICATED THE PAIN WITH A DAILY DOSE OF HEROIN. BEFORE HE CAME INTO OUR PROGRAM HE WAS KNOWN AT THE PRISON AS AN EXTREMELY DANGEROUS INMATE WHO SETTLED HIS CONFLICTS WITH A PAIR OF KNIVES. NOW HE IS A MODEL PRISONER COMPLETELY DRUG AND INCIDENT FREE OVER THE PAST SIXTEEN MONTHS. HE ATTRIBUTES HIS RECOVERY TO OUR PROGRAM WHICH EXPLAINED THE NEGATIVE EFFECT OF INSTITUTIONALIZATION AND HELPED HIM WORK THROUGH IT.

FURTHER, WE LEARNED THAT SOME OF THE MEN SUFFER FROM THE DUAL DIAGNOSES OF SUBSTANCE ABUSE AND PSYCHOLOGICAL DISORDERS REQUIRING MENTAL HEALTH TREATMENT. WE DISCOVERED THAT IN MANY INSTANCES THE MEN WERE ABUSED AS A CHILD, LIVED WITH ALCOHOLIC AND DRUG ABUSING PARENTS, OR SUFFERED THE EFFECTS OF TRAUMATIC CHILDHOOD EXPERIENCES, AND THE PAIN OF GROWING UP IN DYSFUNCTIONAL FAMILIES AND ENVIRONMENTS.

A PERFECT EXAMPLE IS THE CASE OF A MAN WHO AT THE AGE OF NINE YEARS OLD, ALONG WITH TWO SMALLER SIBLINGS, WITNESSED THE FATAL HANGING OF HIS MOTHER BY DRUG DEALERS. IT WAS SHORTLY AFTER THIS HORRIFYING EXPERIENCE, AND BECAUSE HELP WAS NOT READILY AVAILABLE FOR HIM, THAT HE BEGAN USING DRUGS AND WAS LATER ARRESTED FOR DISTRIBUTION. HIS BROTHER AND SISTER ALSO HAVE SUBSTANCE ABUSE PROBLEMS.

WHILE WE DO NOT CONDONE OR EXCUSE THE UNLAWFUL CONDUCT, WE RECOGNIZE THAT HIS CHANCES FOR RECOVERY HINGE UPON TREATMENT WHILE INCARCERATED.

BUT THERE IS GOOD NEWS! ON MARCH 1, 1991, 95 PERCENT OF THE PARTICIPANTS SUCCESSFULLY COMPLETED THE UNFOLDMENT PROGRAM AND MIRACLE OF MIRACLES THEY COMPLETED WITH NO DIRTY URINE AND NO DISCIPLINARY REPORTS -- A FEAT UNHEARD OF IN A 62-MAN MEDIUM SECURITY DORM.

BUT THE HELP CANNOT STOP ONCE THE PERSON LEAVES PRISON. IN ORDER TO GIVE THEM A PRACTICUM IN LIVING LIFE ON LIFE'S TERMS IN A "SQUARE" WAY, WE OFFER A CONTINUUM OF SERVICES UPON RELEASE THAT WE CALL **"AFTERCARE"**

WE OFFER AFTERCARE ON THREE LEVELS. ONE LEVEL IS THE **MINIMUM SECURITY FACILITY COMPONENT**, A SIX-MONTH TO 24-MONTH PROGRAM FOR INMATES PREPARING FOR COMMUNITY TRANSITION. ANOTHER IS THE UNFOLDMENT **HALFWAY HOUSE PROGRAM** WHICH HOUSES PERSONS WITHIN SIX MONTHS OF PAROLE RELEASE. THE HALFWAY HOUSE PROGRAM, SLATED TO BEGIN THIS WEEK, WILL BE A COEDUCATIONAL PROGRAM IN WHICH WE WILL PROVIDE OUR SERVICES TO FEMALE OFFENDERS. THE THIRD IS **THE AFTERCARE HOUSE**, A PRIVATE HOME DESIGNED ON THE OXFORD HOUSE MODEL, WHERE PAROLEES LIVE FOR SIX-MONTHS IN AN EFFORT TO STABILIZE THEMSELVES BEFORE GOING HOME TO THEIR FAMILIES.

IN ALL OF THESE AFTERCARE PROGRAM COMPONENTS PARTICIPANTS ARE ASKED TO **GIVE BACK TO THE COMMUNITY BY REHABILITATING COMMUNITY PROPERTIES.** FIFTEEN MEN IN OUR PROGRAM ARE CURRENTLY RENOVATING A BUILDING THAT WAS FORMERLY AN ABANDONED CRACK HOUSE IN FAR SOUTHEAST AS PART OF THEIR WAY OF GETTING INVOLVED IN POSITIVE CIVIC ACTIVITIES.

THE UNFOLDMENT PROGRAM THEN IS THE DISTRICT'S FIRST EFFORT TO PROVIDE A CONTINUUM OF SUPPORT TO THIS POPULATION.

II. **WE CITE SEVERAL MILESTONES OF SUCCESS DURING THE PAST 16 MONTHS:**

1. RECENTLY, IN A CASE INVOLVING SIMPLE POSSESSION AND DISTRIBUTION, **U.S. DISTRICT COURT JUDGE LOUIS OBERDORFER, CITED THE UNFOLDMENT PROGRAM AS THE BASIS FOR DEPARTING DOWNWARD FROM THE FEDERAL SENTENCING GUIDELINE FOR AN UNFOLDMENT PARTICIPANT. (SEE ATTACHED,** UNITED STATES V. KELVIN HARRINGTON**, 741 F. SUPP. 968)**

2. FURTHER EVIDENCE OF JUDICIAL SUPPORT FOR OUR PROGRAM OCCURRED IN FEBRUARY OF THIS YEAR WHEN D.C. SUPERIOR COURT JUDGE SYLVIA BACON REDUCED THE SENTENCE OF ONE OF OUR PARTICIPANTS CITING THE UNFOLDMENT PROGRAM AS THE BASIS FOR HER ACTION. (SEE ATTACHED OPINION UNITED STATES V. EZZARD LAWRENCE)

3 WE HAVE EXPERIENCED NO DISCIPLINARY REPORTS OR DIRTY URINE AMONG THE 62 MEN HOUSED IN A MEDIUM SECURITY FACILITY DURING THE ONE-YEAR COURSE OF THE PROGRAM.

4. CORRECTIONAL OFFICERS SUPPORT THE PROGRAM AND COMPETE FOR ASSIGNMENT TO OUR PROGRAM DUE TO CLEAN DORMS AND THE RESPECTFUL MANNER OF THE PARTICIPANTS. OFFICERS SEEKING CERTIFIED ADDICTION COUNSELOR (CAC) CREDITS REQUEST ASSIGNMENT TO OUR PROGRAM TO FULFILL THEIR PRACTICUM.

5. WE RECENTLY RECEIVED AN INVITATION BY THE D.C. DEPARTMENT OF CORRECTIONS TO ASSIST IN DEVELOPING A DEPARTMENT-WIDE POLICY GUIDELINE FOR OPERATING A RESIDENTIAL THERAPEUTIC TREATMENT COMMUNITY WITHIN A PRISON AND IN CROSS TRAINING TREATMENT AND SECURITY STAFF.

6. WE ARE EMBARKING ON THE FIRST YEAR OF OUR CAC TRAINING PROGRAM FOR GRADUATES OF THE FIRST CLASS.

7. **WE HAVE BEEN ASKED BY THE DEPARTMENT TO EXPAND OUR PROGRAM FROM 60 TO 240 BEDS IN FISCAL YEAR 1992 TO ACCOMMODATE OUR WAITING LIST OF MORE THAN 500.** HOWEVER, NO FUNDS HAVE BEEN IDENTIFIED FOR THIS EXPANSION AND WE ARE CURRENTLY NEGOTIATING THE BUDGET FOR THIS EXPANSION WITH THE DEPARTMENT.

II. RECOMMENDATIONS FOR THE PROPOSED H.R. 730 AND H.R. 548 BILLS

WE FULLY SUPPORT BOTH BILLS. WE URGE CONGRESS TO MOVE QUICKLY TO PROVIDE MUCH NEEDED FUNDING FOR SUCH PROGRAMS. WE RECOMMEND THAT YOU CONSIDER THE FOLLOWING AMENDMENTS TO H.R. 730 AND 548:

1. THE LEGISLATION SHOULD MANDATE THAT PRISON-BASED DRUG TREATMENT BE PROVIDED BY COMMUNITY-BASED NON-PROFIT ORGANIZATIONS. WHERE SUCH PROGRAMS ARE ADMINISTERED BY CORRECTIONS PERSONNEL, IT IS DIFFICULT FOR INMATES TO TRUST. TRUST OF THE PROGRAM, PROCESS AND TREATMENT PROFESSIONALS BY PARTICIPANTS IS ESSENTIAL TO SUCCESS.

WE ALSO DISCOURAGE CORRECTIONS ADMINISTERED TREATMENT PROGRAMS BECAUSE IT IS DIFFICULT FOR CORRECTIONAL AND SECURITY PROFESSIONALS TO IMPLEMENT THE CRITICAL MODALITIES OF A SUCCESSFUL TREATMENT MODEL SINCE THESE ELEMENTS MAY CONFLICT WITH EXISTING DEPARTMENT REGULATIONS.

2. THE LEGISLATION SHOULD ALLOW FOR THE DIRECT ALLOCATION OF GRANT FUNDING FROM THE FEDERAL LEVEL TO APPROPRIATE NON-PROFITS FOR BOTH THE PRISON-BASED AND HALFWAY HOUSE SUBSTANCE ABUSE TREATMENT PROGRAMS. NON-PROFITS WHO HAVE ACHIEVED SUCCESS IN THIS DIFFICULT FIELD SHOULD ALSO BE ALLOWED TO PROVIDE TECHNICAL ASSISTANCE TO FEDERAL AND STATE GOVERNMENTS IN IMPLEMENTING THIS NEW LAW.

3. BECAUSE AFTERCARE IS VITALLY IMPORTANT TO RECOVERY, THE LEGISLATION SHOULD ENCOURAGE THE DEVELOPMENT OF OXFORD HOUSE TYPE PROGRAMS FOR PAROLEES, WHO BECAUSE OF THEIR SENTENCE STRUCTURE MAY NOT HAVE THE BENEFIT OF HALFWAY HOUSE SUBSTANCE ABUSE TREATMENT AFTER THE PRISON-BASED PROGRAM.
THESE PROGRAMS SHOULD BE OPERATED BY COMMUNITY-BASED NONPROFITS EXPERIENCED IN WORKING WITH PRISONERS AND SUBSTANCE ABUSERS TO ASSIST IN A SUCCESSFUL REINTEGRATION OF INMATES INTO THE COMMUNITY.

4. THE LEGISLATION SHOULD MANDATE THAT GRANTEES INCORPORATE THE ESSENTIAL COMPONENTS OF A SUCCESSFUL COMPREHENSIVE TREATMENT MODEL AS SET FORTH IN PROGRAMS SUCH AS MT. MCGREGOR AND UNFOLDMENT INC.

5. THE LEGISLATION SHOULD MANDATE THAT DRUG TREATMENT BE AVAILABLE FOR EVERY INMATE WANTING TREATMENT AND WILLING TO UNDERGO THE RIGOROUS STRUCTURED REQUIREMENTS. HOWEVER, TREATMENT SHOULD NOT BE MANDATED.

6. THE LEGISLATION SHOULD SPECIFICALLY EARMARK FUNDING FOR WOMEN AND FEMALE JUVENILE OFFENDERS IN AN AMOUNT COMPARABLE TO THEIR NEEDS, AS THE CRACK EPIDEMIC HAS RESULTED IN DRASTIC INCREASES IN THE NUMBERS OF WOMEN AND FEMALE JUVENILES ENTERING THE CRIMINAL JUSTICE SYSTEM.

7. FUNDING SHOULD BE INCLUDED FOR RESEARCH AND EVALUATION OF THESE PROGRAMS.

IT HAS BEEN A PLEASURE SHARING THE UNFOLDMENT EXPERIENCE WITH YOU THIS AFTERNOON. WE STAND WILLING TO ASSIST THE COMMITTEE IN ASSURING THAT PRISONS PROVIDE TREATMENT FOR THE THOUSANDS OF FEDERAL AND STATE PRISONERS WHO NEED AND WANT IT.

ATTACHMENTS

* LETTER OF SUPPORT FROM U.S. DISTRICT COURT JUDGE JUNE GREEN
* STATEMENT OF COVINGTON AND BURLING ATTORNEY ALAN PEMBERTON
* LETTER OF SUPPORT FROM D.C. BAR PRESIDENT JAMES ROBERTSON
* OPINION OF U.S. DISTRICT COURT JUDGE LOUIS OBERDORFER, U.S. V. KELVIN HARRINGTON
* OPINION OF D.C. SUPERIOR COURT JUDGE SYLVIA BACON, U.S. V. EZZARD LAWRENCE

UNITED STATES DISTRICT COURT
FOR THE
DISTRICT OF COLUMBIA
WASHINGTON 20001

JUNE L. GREEN
JUDGE

January 22, 1991

Kemi Morten, Executive Director
Unfoldment, Inc.
2605 Wade Road, S.E.
Washington, D.C. 20020

Dear Ms. Morten:

Congratulations on the outstanding success of Unfoldment's first year. The change in the participants has been phenomenal. They have developed self-respect and show responsibility for their own actions. These are certainly the cornerstones of abstinence from narcotics.

The question that recurs is what happens to these individuals when they are no longer under restraints? It is my understanding that Unfoldment is proposing such a research project, not only to ascertain the success of Unfoldment's graduates, but to identify factors that may predict their return to drug abuse or other criminal behavior.

It appears that the research project would be directed toward different or ongoing treatment for those addicts found to be at high risk. The better one is able to identify effective treatment, the more successful rehabilitative programs will become.

I wish Unfoldment every success in this research project.

Very truly yours,

June L. Green

COMMITTEE ON THE JUDICIARY
COUNCIL OF THE DISTRICT OF COLUMBIA

March 14, 1991

STATEMENT OF ALAN A. PEMBERTON,
COVINGTON & BURLING

P.O. Box 7566
1201 Pennsylvania Ave., N.W.
Washington, D.C. 20044
(202) 662-6000

STATEMENT OF ALAN A. PEMBERTON,
COVINGTON & BURLING

Good afternoon. I thank the members of the Committee for permitting me to testify this afternoon in support of an extension and expansion of the funding for the Unfoldment drug rehabilitation program within the Department of Corrections budget.

As the Committee is aware, the Unfoldment program's first year of operations at the Central Facility was funded by a grant from the District Court, out of a fund of fines that the Court had imposed on the District for overcrowding at the facility. My firm has handled the Central Facility litigation, Twelve John Does v. District of Columbia, since 1980.

The Unfoldment program has had a very successful first year of operation, as the Committee will undoubtedly hear from other witnesses. I would like to offer the viewpoint of a lawyer concerned with prison conditions at Lorton. If all of the Central Facility were operated the way the Unfoldment program is, there would be no need for litigation challenging the conditions at Lorton -- Central would be a model prison. The dormitory that Unfoldment took over for its program was as decrepit and dirty as most of the other dormitories at the facility a year ago. Now it is a showplace. The assault rate in the Unfoldment dormitory is so low as to be nonexistent. The Unfoldment model ought to be applied as broadly as possible throughout the Department.

Two things make the Unfoldment program particularly noteworthy. First, it is a program that the inmates feel that they helped to bring to the prison. That gives them a stake in the success of the program that is helpful on many levels. There is a powerful sense of community that is apparent to everyone who visits the program. The program tends to attract inmates who are sincerely interested in self-improvement. And when they leave the program, graduates are going to feel that they are letting down their Unfoldment family if they regress to their old ways.

Second, the program has a strong cultural component, and has a strong base in the Washington community. The strong cultural component seems to be an important part in building the very obvious self-respect that the program participants have developed. That self-respect is not something that many inmates gain in prison, and it is bound to be an important factor in preventing a recurrence of drug use. The program's strong roots in the local community mean that the Unfoldment organization has an interest in these men after they leave prison. The prisons are full of people who didn't receive that kind of attention the first time they were released.

Programs like Unfoldment may cost more in the short term than simply warehousing inmates does. But if such programs really make a dent in the drug and recidivism problems, they will be a bargain in the long term. Thank you.

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THE DISTRICT OF COLUMBIA BAR

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March 6, 1991

Kemi Morten, Esq.
Executive Director
Unfoldment, Inc.
2605 Wade Road, S.E.
Washington, D.C. 20020

Dear Kemi:

Maybe I sensed "trouble in the air overhead" when I wrote you recently to congratulate you on Judge Oberdorfer's opinion -- and you responded with the invitation to your first graduation ceremony. Whatever the cause, it was for me a very lucky chain of events. I was very impressed by the program you and your colleagues put on. Thank you for your welcoming remark to me.

I hope I was never a "naysayer" about your program. I will confess to doubt. Doubt is hard to put aside when it comes to addiction. But the performance of USATP, at least to this point, looks like a stunning accomplishment, and it certainly pushes doubt to one side. You deserve all of the many "big hands" you received the other day, and lots more besides. I wish you the best of luck in the future of your program, and I am happy to be considered its friend. I hope there is some way in which I can use my soon-to-be-adopted D.C. Bar title constructively and supportively in our common cause.

Sincerely yours,

James Robertson

Sara-Ann Determan
President
James Robertson
President-Elect
Darryl W. Jackson
Secretary
Alan I. Herman
Treasurer

Board of Governors:
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Robert N. Weiner
Thomas Williamson, Jr.

Judith Richards Hope
General Counsel

Katherine A. Mazzaferri
Executive Director
Charles E. Lorenzetti
Assistant Executive
Director, Administration
and Finance
Cynthia D. Hill
Assistant Executive
Director, Programs

a clear statutory right on behalf of the petitioner; (2) the absence of discretion on the part of the government official or employee charged with the correlative duty; and (3) the inadequacy of any other remedy. *Trahan v. Regan*, 554 F.Supp. 57 (D.D.C.1982), *vacated in part on other grounds, Tierney v. Schweiker*, 718 F.2d 449 (D.C.Cir.1982). The All Writs Act also requires the absence of alternative remedies. *See Telecommunications Research & Action Center v. FCC*, 750 F.2d at 78.

[3] The Court finds that petitioner has not shown an absence of other available remedies. Under the statutory scheme for the reexamination of patents, petitioner has several alternatives. Petitioner had the opportunity to file a statement on the decision that a substantial new question of patentability was raised, but did not do so. Although petitioner chose not to file within the time limits, it appears that petitioner may still prosecute the claims in the patent and any other claims that are within the scope of the patent claim via proposed amendments. 35 U.S.C. § 305. Petitioner's remedies do not end there. Once the examiner makes a final decision pursuant to the procedures established under 35 U.S.C. § 132, and § 133, petitioner may appeal the final decision of the patent examiner to the Board of Patent Appeals and Interferences. If still dissatisfied with the results, petitioner may seek judicial review under 35 U.S.C. §§ 141-145. 35 U.S.C. § 306. Any evidence of bias could be ferreted out in this multi-step process.

Petitioner, however, argues that Examiner Larkins's bias cannot be resolved through this process and that the decision of the Office of the Commissioner is final. Petitioner's position places the respondent in a difficult position. Respondent cannot defend or ask Examiner Larkins to explain or exonerate his alleged statements without justifiably causing some potential bias. Thus, respondent is forced to look at the record for bias, which it did not find. There being no non-discretionary duty owed by respondent to petitioner, the Court will not use its mandamus powers to order the removal of Examiner Larkins. Petitioner has several other potential remedies which it should pursue. Accordingly, it hereby is

ORDERED, that the petition for a writ of mandamus is denied.

That requested relief having been denied, and it being clear that the Special Assistant's decision of April 24, 1990, is non-final (and would not be reviewable in this Court if it were final), for the reasons stated in [Respondent's] Motion To Dismiss (which does not appear to have been opposed), it hereby further is

ORDERED, that the case is dismissed.

SO ORDERED.

UNITED STATES of America

v.

Kelvin HARRINGTON, Defendant.

Crim. No. 89-0138-01-LFO.

United States District Court, District of Columbia.

July 13, 1990.

In sentencing defendant convicted of distribution of cocaine base and possession with intent to distribute cocaine and cocaine base, the District Court, Oberdorfer, J., held that likelihood of defendant's successful completion of prison drug treatment program warranted downward departure from guideline range.

Ordered accordingly.

1. Criminal Law ⇐996(1)

District court had authority to vacate sentence imposed earlier on same day, where court invited counsel to move for reconsideration after initially imposing sentence, and defendant did not leave courthouse between hearing in which sentence

was imposed and hearing in which sentence was vacated with view to appointing amicus curiae. Fed.Rules Cr.Proc.Rule 35(a), 18 U.S.C.A.

1. Criminal Law ⇐1239

Defendant's prospect of rehabilitation was factor to be considered in determining whether upon prison sentence under Sentencing Guidelines. 18 U.S.C.A. § 3553(a)(2).

2. Criminal Law ⇐1299

In sentencing defendant under Sentencing Guidelines, departure is permitted where expert opinion and other evidence leads to a finding that successful treatment for defendant's drug addiction is likely. 18 U.S.C.A. § 3553(b); U.S.S.G. § 5K2.0, p.s., 18 U.S.C.A.App.

3. Criminal Law ⇐1299

Evidence that defendant, a drug addict, had successfully participated in drug treatment program while released to third-party custody and was likely to benefit from prison drug treatment program warranted downward departure from Sentencing Guidelines recommended range for possession of cocaine base and possession with intent to distribute cocaine and cocaine base. Comprehensive Drug Abuse Prevention and Control Act of 1970, § 401(b), 21 U.S.C.A. § 841(b); 18 U.S.C.A. § 3553(a)(2); U.S.S.G. § 5K2.0, p.s., 18 U.S.C.A.App.

Mark Ehlers, Asst. U.S. Atty., Thomas J. Gruenski, Asst. U.S. Atty., Washington, D.C., for U.S.

Christopher W. Hall, Washington, D.C., for defendant.

STATEMENT OF REASONS FOR DEPARTURE FROM THE SENTENCING GUIDELINES

OBERDORFER, District Judge.

On June 29, 1989, a jury found Kelvin Harrington guilty of distribution of cocaine base and possession with intent to distribute cocaine and cocaine base. On September 14, 1989, the Court imposed a guideline sentence of 97 months incarceration, but vacated that sentence a few hours later that day. *See* Transcript of September 14, 1989 ("Sept. Tr.") (filed Sept. 21, 1989) at 1. On the same day, the Court also vacated a sentence of 108 months incarceration imposed on September 11, 1989, on DeWayne Shorter and deferred sentencing of Kevin D. Jameson, both of whom had been convicted of drug offenses. On June 27, 1990, the Court sentenced Harrington to the mandatory minimum term of 60 months imprisonment pursuant to 21 U.S.C. § 841(b), with an additional four year term of supervised parole. Judgment Including Sentence Under the Sentencing Reform Act (filed June 29, 1990). On June 27, 1990, the Court also sentenced DeWayne Shorter to a sentence within the guideline range, stating considerations that distinguished Harrington's case from Shorter's and indicating that they would be the subject of a memorandum to be filed. Transcript of June 27, 1990 ("June Tr."). This is that memorandum with respect to defendant Harrington, which, pursuant to 18 U.S.C. § 3553(c)(2), sets forth the specific reasons for the June 27, 1990 imposition of a sentence outside the guidelines range.

I.

A.

Kelvin Harrington is a 30-year-old drug addict who has been using drugs since he was 17 years old.[1] On April 6, 1989, he was arrested and charged with the offenses for which he was later found guilty. It was his first offense or arrest. Following arrest he was released to third party custody, subject to electronic monitoring. From May 10 to June 28, 1989, he participated in Operation Progress, a drug treatment program sponsored by the D.C. Department of Corrections. Clinton R. Boyd, Chief, Office of Rehabilitative Services, D.C. Department of Corrections, reported that:

[1] Harrington began his drug use in 1977, used marijuana daily and cocaine every other day. He told the Probation Officer that his drug use interferes with his ability to maintain employment and "got out of hand" in the past two years. Presentence Report (July 24, 1989) at 8.

Mr. Harrington's participation in Operation Progress was excellent. He attended and participated in both group and individual counselling sessions. He submitted the required number of urine specimens and all were returned negative for illicit drug usage.

On May 24, 1989, Mr. Harrington secured employment on his own initiative with Temporary Personnel Pool Services, located in Arlington, Virginia. He was a Pool Technician Helper and his salary was $5.00 per hour.

Evaluation

Mr. Harrington complied with the mandated [sic] of the Program. He was able to focus on his situation and was able to display a level of maturity while he was in the program.

He displayed a desire to become a productive member of society. With continued counselling and vocational training, he could advance to a correction where he would not return to illegal means to maintain himself economically.

Recommendation

Based on Mr. Harrington's successful participation while in Operation Progress and his willingness to comply with the rules and regulations, it is respectfully requested that insightful consideration be given to him during sentencing that is consisted [sic] with his present adjustments.

Letter from Clinton R. Boyd (February 9, 1990) at 2.

The probation officer who prepared Harrington's Presentence Report (without benefit of the Operation Progress report) found the mandatory minimum sentence prescribed by Congress to be 60 months and the guideline range to be 97 to 121 months; he recommended a sentence of 97 months followed by four years of supervised release on the condition that during release Harrington participate in drug treatment. Presentence Report at 12.[1]

In the proceeding on the morning of the 14th, Harrington's appointed counsel stated:

> . . . I am disturbed, given the fact that [the Guidelines] called for an exposure of anywhere from 8 to 12 years, given that this is Mr. Harrington's first offense [sic], and in reviewing the sentencing guidelines and the Commission's statements on them, it is clear that, unless the Court feels that it can depart for the lack of defendant's criminal history, that the Court would have to give a sentence in that range.
>
> . . . The defendant did go to trial, but he insisted all along that he was innocent of both offenses, that he was not the person who did the sale on March 30th, nor did he possess the crack and the cocaine that was found in the kitchen in the house where he was present, along with two other individuals.
>
> The defendant is as [sic] high school graduate, he did have something of a work history prior to his arrest in these cases, and while he was a drug user the defendant maintains that he was never a seller.
>
> . . . In any event, given all that, that's why we would ask the Court to consider whether or not it could depart from the guidelines and go downward . . .

Sept. Tr. at 2-3.

Harrington then addressed the Court, repeating counsel's request for a downward departure from the Guidelines and further stating:

> I never possessed anything and I feel that, as far as me being a drug addict, this isn't the way that a problem should be handled. I need help, not incarceration, and it has taken me this to get help. . . . 'R]ight now it is a bad time as far as . . . being involved in any type of drug thing, but I am not a dealer that possessed all of these so-called thousands of dollars and all of these grams of cocaine . . .

Sept. Tr. at 4. The Court expressed concern that the Sentencing Commission may not have given "adequate consideration to the possibility or probability that a [first offender drug addict who] is susceptible to treatment and rehabilitation [could] be restored to the community in a way that

1. The Presentence Report did not anticipate drug treatment during incarceration.

somebody who served 9 years might not be. Sept. Tr. at 13–14. The Court nevertheless imposed a sentence of 97 months plus four years supervised release on the condition, among others, that "upon release," Harrington participate in a drug program. Sept. Tr. at 6–7. Upon completion of the morning sentencing process the Court requested that Harrington be retained in the area "for the period required by . . . counsel to prepare an application for reduction of sentence, so that you can cooperate with them in doing that." Sept. Tr. at 7.

[1] Harrington's case was one of a series of sentencing hearings of drug addict defendants in a brief time span in which the Sentencing Guidelines appeared to the Court to require sentences substantially greater than the very substantial minimum sentences mandated by Congress. Increasingly concerned as to whether the Sentencing Guidelines did, or could validly, mandate such sentences in first offender drug addict cases where the potential for successful drug treatment was high, and recognizing how difficult it was for court-appointed lawyers, or the Court itself, adequately to evaluate the relevant jurisprudence and literature, the Court appointed Bruce Baird, Esq., a former Assistant United States Attorney in the Southern District of New York and now a member of the firm of Covington and Burling, as *amicus curiae* to address the question of whether such sentences were required by law. For those reasons, later on the same day, the Court vacated Harrington's 97 month Guideline sentence with a view to imposing sentence after receipt of the advice of *amicus*. *See* Fed.R.Crim.P. 32(a)(1).[3]

B.

On November 1, 1989, *amicus* filed a comprehensive memorandum which collected relevant precedents and scientific literature on drug abuse. *Amicus* concluded that although the Sentencing Guidelines are facially constitutional and do not impermissibly intrude on, *inter alia*, the due process rights of litigants, the Guidelines pass due process muster in part because sentencing judges are permitted to depart from the Guidelines in appropriate cases. Memorandum of Law of Amicus Curiae on Sentencing Guidelines Issues (Nov. 1, 1989) ("Amicus Memorandum") at 15. *Amicus* noted that important mitigating factors not considered in the Guidelines constituted grounds for departure as stated explicitly in both the statutes and the Guidelines:

> The purposes of the United States Sentencing Commission [include] . . . maintaining sufficient flexibility to permit individualized sentences when warranted by mitigating or aggravating factors not taken into account in the establishment of [the Guidelines]

28 U.S.C. § 991(b)(1)(B). Specifically, *amicus* noted that the authorizing statute allows a court to depart if it finds:

> that there exists an aggravating or mitigating circumstance of a kind, or to a degree, not adequately taken into consideration by the Sentencing Commission in formulating the guidelines that should result in a sentence different from that described.

[3] At the September 14, 1989 hearing, the government indicated some doubt as to the Court's authority to vacate the sentence imposed earlier that day. Sept. Tr. at 13. In point of fact the Court reluctantly imposed sentence on September 14 at about 9:30 A.M. and invited counsel to move for reconsideration. Sept. Tr. at 7. The hearing resumed at 2:00 P.M. at which time the Court vacated the sentence with a view to appointing *amicus curiae*. The defendant did not leave the courthouse until after the afternoon hearing, which he attended.

It is well established in this circuit that a district court may modify a sentence until the time at which the defendant begins to serve it. It has never been doubted that a district court retains the power to recall the defendant and increase the severity of the sentence at any time before he begins to serve the sentence and at common before he leaves the courthouse. *United States v. Jordan*, 810 F.2d 262, 268 n. 1 (D.C.Cir.1987); *see also United States v. Fogel*, 829 F.2d 77, 84 (D.C.Cir.1987); *United States v. Davidson*, 597 F.2d 230 (10th Cir.1979); *Walton v. United States*, 202 F.2d 18, 19–20 (D.C.Cir. 1953); *Miller v. Swope*, 13 F.2d 68, 69 (N.D.Ga. 1926). The same principles which establish that the sentencing process continues while a defendant is still in the courthouse so as to permit an increase in its severity apply with equal force to permit vacation of a sentence while the defendant is still in the courthouse.

18 U.S.C. § 3553(b) (Supp. V 1987). *Amicus* also pointed out that Sentencing Guideline § 5K2.0 has implemented this congressional authorization for departure by a sentencing court:

> Circumstances that may warrant departure from the guidelines pursuant to this provision cannot, by their very nature, be comprehensively listed and analyzed in advance. The controlling decision as to whether and to what extent departure is warranted can only be made by the court at the time of sentencing.... Any case may involve factors in addition to those identified that have not been given adequate consideration by the Commission. The presence of any such factor may warrant departure from the guidelines, under some circumstances, in the discretion of the sentencing judge. Similarly, the court may depart from the guidelines, even though the reason for departure is limited elsewhere in the guidelines (*e.g.*, as an adjustment or specific offense characteristic), if the court determines that, in light of the unusual circumstances, the guideline level attached to that factor is inadequate.

Guideline § 5K2.0. *See also* Guideline 5H1.3. Distinguishing between addiction, which may not be considered in sentencing pursuant to Guideline § 5H1.4 [2], and the likelihood of rehabilitation from drug addiction, *amicus* concluded that the likelihood of successful treatment of addiction was a factor not considered in the Guidelines and therefore was a basis for departure. *Id.* at 30. After canvassing the literature on the effectiveness of drug treatment on drug use and criminal behavior, *amicus* found that "despite doubts regarding the efficacy of drug treatment programs in the mid-70s ... recent research reveals that such treatment can be effective, in terms of reducing both drug use and criminal behavior." *Id.* at 31.

Amicus also determined that while amenability to successful drug treatment cannot be measured prior to an individual's entering a drug treatment program, *id.* at 34, there is a correlation between successful drug treatment and an individual's social and ongoing behavior and responses while in a drug treatment program. *Id.* at 34–35. In addition, *amicus* observed that certain psychiatric characteristics have been negatively correlated with successful drug treatment, such as antisocial personality disorder, avoidance, dependance, and paranoia and that psychiatric testing could be useful to a court in determining the likelihood of rehabilitation. *Id.* at 37–39. *Amicus* suggested that the likelihood of successful treatment could be determined both from objective factors including those listed in the Presentence Reports and by expert psychiatric testing. *Id.* at 39.

C.

The government, responding to *amicus*, argued that since "rehabilitation has been rejected as a goal in sentencing" and drug dependence is not a basis for departure under Guideline § 5H1.4, the court could not depart in this instance. Government's Memorandum in Aid of Sentencing ("Government Memorandum") (December 20, 1989) at 9. The government further argued that while the Sentencing Guidelines do not eliminate the court's discretion, "[d]epartures should be granted only in atypical cases where a defendant's conduct differs significantly from the norm." *Id.* at 8. Finally, the government contended (without citation of authority) that "successful" drug treatment has "never been defined[4] and, in the actual field of substance abuse treatment programs, does not exist (sic)."[5] *Id.* at 11. According to the

4. *Amicus* noted, however, that a candidate for successful drug treatment was defined in the Narcotic Addicts Rehabilitation Act of 1966 as "an addict likely to be rehabilitated through treatment." 18 U.S.C. §§ 4252–53 (repealed as part of blanket repealer of pre–1987 sentencing statutes). Pub.L. 98–473, 98th Cong., 2d Sess. (1984).

5. *But compare Understanding Drug Treatment*, An Office of National Drug Control Policy White Paper (June 1990) stating:

> We now know on the basis of more than two decades of research that drug treatment can work.

Id. at 30, and further stating:

government, drug addiction is a "disease that subjects the addict to potential relapse at any time.... Even total abstinence cannot be termed successful since the addict always carries the disease...." *Id.* at 12 (Emphasis in original). The government concluded that "[i]t therefore seems counterproductive to further expend government resources in an attempt to determine adequate drug treatment for these defendants at this time." *Id.*

D.

On January 25, 1990, when the Court confronted major surgery and a long convalescence, Magistrate Patrick Attridge accepted responsibility for carrying on administration of this matter and making a recommendation to the Court as to whether a sentencing judge may depart from the Guidelines sentence range where drug treatment of an addict defendant appears likely to succeed and, if so, whether these particular defendants should be the subject of such a departure. Magistrate Attridge arranged for Harrington (and Shorter) to be examined by Dr. Joseph Chambers, a psychiatrist specializing in alcoholism and drug abuse, and his associate Donald Streater who would then provide the Court with expert opinions. On June 4, 1990, the government and the several defendants stipulated that the reports of Dr. Chambers and Mr. Streater represented the record in place of testimony at a hearing before Magistrate Attridge and that Dr. Chambers and Mr. Streater were "experts in the field of addiction to controlled substances and qualified to give expert opinions on whether Kelvin Harrington was such an addict when he was arrested ... and what his present chances are for successful rehabilitation." Stipulation (June 1, 1990).

Dr. Chambers interviewed Harrington on April 2 and April 21, 1990. The April 2 interview was at the D.C. Jail. Harrington had been participating since March 1 in the Unfoldment Substance Abuse Treatment Program sponsored at Lorton by Twelve John Does and the D.C. Department of Corrections. At this first interview, Dr. Chambers found Harrington to be "compliant, cooperative and polite," but upset at being taken away from "his intense drug rehabilitation program at Lorton which is clearly quite important to him." Letter of Dr. Joseph F. Chambers to Christopher W. Hall ("Chambers Letter") (April 24, 1990) at 1.

At the April 21 interview, conducted at Lorton, Dr. Chambers found Harrington, a high school graduate and former football star, to be "bright, self-centered, capable and assertive." *Id.* The doctor observed him to be "tall, handsome, and in excellent physical shape." *Id.* Dr. Chambers was impressed by Harrington's vigorous pursuit of admission into the Unfoldment Program. Dr. Chambers found that Harrington had been enrolled in the program for seven weeks and was an active participant. With respect to the program, Dr. Chambers observed:

> This is a 48-week, 12 hour/day intense program which emphasizes personal responsibility, self discipline and orderly living. It is based on the "12 step" philosophy of living. *Its intensiveness and discipline equals any program I have seen.* It is possible for him to repeat this 48-week program.

Id. (Emphasis added.)

From the interviews and the Presentence Report which had been made available to him, Dr. Chambers concluded:

> He was open, and seemed honest and willing. More importantly, if he can become concerned about others, and if he can continue his current intense commitment to the treatment throughout his incarceration, and possible parole, the long term prognosis is quite favorable. Most men who do accept this way of life do succeed.

Id. at 2.

E.

Dr. Chambers' report is strongly corroborated by the recently released Office of

Id. at 22.

Drug treatment may be deemed successful when three to five years after treatment, a former addict is no longer using drugs.

National Drug Control Policy White Paper entitled *Understanding Drug Treatment*, June 1990, issued by William J. Bennett, Director, Office of National Drug Control Policy ("White Paper"), a document not in existence and therefore not considered by the Sentencing Commission or the Magistrate when they formed their respective opinions.

> The White Paper states unequivocally: "We now know on the basis of more than two decades of research that drug treatment can work.

Id. at 80. The White Paper recognized that:

> [A]ddicts never emerge from a treatment program completely "cured." In fact it is only after they leave the relatively protected environment of a treatment program that they face the greatest challenges to their efforts to stay off drugs.

Id. at 21. However, the White Paper emphasized with respect to drug treatment for prison inmates:

> . . . Most convicts who were once heavily involved with drugs finish their prison terms without having any drug treatment[6], and many return to a life of drugs and crime upon release.
>
> Of course, prisons are designed to incapacitate criminal offenders and provide just punishment. But prisons can also provide a useful setting for drug treatment: drugs are harder to come by inside a prison; drug testing and accountability are usually not new to correctional facilities; and inmates preparing for release are sometimes eager to find a way out of the type of behavior that put them in prison in the first place.

Id. at 28. In language strikingly paralleling that of Dr. Chambers, the White Paper observed:

> The ethos of personal accountability and adherence to rules that pervades the criminal justice system is frequently a part of effective drug treatment. Good treatment programs insist on a code of conduct, individual responsibility, personal sacrifice, and sanctions for misbehavior. There is now an impressive amount of evidence to suggest that when drug treatment contains these elements, we get results: addicts change their self-destructive pattern of behavior and stop or dramatically reduce drug use. That's why drug treatment and criminal justice must be understood as allies in our fight against drug use.

Id. at 1–2.

II.

A.

After receiving the psychiatrists' opinions, but without benefit of the White Paper, Magistrate Attridge filed a careful report, recommending that the Court sentence all three defendants within the guidelines ranges. Report and Recommendation (June 21, 1990). Magistrate Attridge based his legal recommendations on Congress' rejection of the theory that imprisonment should promote rehabilitation, drawing on *Mistretta v. United States*, 488 U.S. 361, 109 S.Ct. 647, 650–51, 102 L.Ed.2d [illegible] (1989) and its discussion of the legislative history reported in Senate Report No. 98-225 (1983), *reprinted in* U.S.Code Cong. & Admin.News 1984 p. 3182. In addition, he cited Guideline 5H1.4's specific statement that drug dependency does not justify downward departure from the Guidelines. *Id.* at 10–11 & n. 15. On these grounds, the Magistrate concluded that the possibility of rehabilitation was considered and rejected by both the Sentencing Commission and Congress. Report and Recommendation at 11. In addition, the Magistrate found Dr. Chambers' and Mr. Streuer's reports on Harrington's potential for drug rehabilitation to be "equivocal factually." *Id.* at 14.

B.

The Magistrate seems to have concluded that departure from the Guidelines was

6. Harrington's Presentence Report seemed to have contemplated that in the usual case there would be no drug treatment until after eight years imprisonment, the treatment to begin only during supervised release. In this case Harrington has already participated in Operation Progress and the Unfoldment Program.

respect to an addict who is likely to succeed a drug treatment is impermissible because Congress rejected rehabilitation as a goal of sentencing. In fact, however, Congress did not foreclose consideration of the likelihood of successful drug treatment as a factor to be considered in sentencing a first offender addict. As *amicus* the Magistrate and the government have observed, Congress, in implementing the Sentencing Reform Act of 1984, did "reject[ ] imprisonment *as a means* of promoting rehabilitation." *See Mistretta*, 109 S.Ct. at 652, citing 28 U.S.C. § 994(k) (emphasis added). However, imprisonment imposed for the purpose of rehabilitation is distinguishable from the possibility of rehabilitation as an appropriate factor in determining the length of a sentence. Congress, discussing the purposes of the Sentencing Reform Act of 1984, 18 U.S.C. 3551 *et seq.*, specifically acknowledged this distinction:

> The fourth purpose is to provide rehabilitation. During the hearings concerning the revision of the Federal Criminal Code arguments were advanced that rehabilitation should be eliminated completely as a purpose of sentencing. The Committee has rejected this view. Instead the Committee has retained rehabilitation and corrections as an appropriate purpose of a sentence, while recognizing, in light of current knowledge, that imprisonment is not an appropriate means of promoting correction and rehabilitation.

Senate Committee on the Judiciary, S.Rep. No. 98-225, 98th Cong., 2d Sess. (1983) at 76, *reprinted in* U.S.Code Cong. & Admin. News 1984, 3182, 3259-60 (citations omitted) (derived from S. 1762, 98th Cong., 2d Sess. (1984)).[1]

The Senate Report plainly stated:

> The Committee does not suggest that efforts to rehabilitate prisoners should be abandoned.

And further stated that:

> The purpose of rehabilitation is still important in determining whether a sanction other than a term of imprisonment is appropriate in a particular case.

Id. at 3259, 3260.

C.

[2] Since Congress did not foreclose consideration of a defendant's prospect of rehabilitation as a factor to be considered in determining the duration of a prison sentence, the question remains whether the Commission considered the prospect that a defendant was a likely prospect for successful drug treatment so as to preclude departure from the Guidelines based on that factor. However, on oral argument about one of the related sentences, *amicus* advised the court that, employing the vast resources of Covington & Burling, he had found no direct evidence of Sentencing Commission consideration of amenability to successful drug treatment as a factor in sentencing. Nor has the Court. Examination of the four corners of the Guidelines and official comment on them provides no indication that the Commission addressed the case of a first offender drug addict found by expert opinion to be a likely candidate for successful treatment for drug addiction. *See United States v. Pipes*, 688 F.Supp. 191, 193 (D.Md.1988) ("sources to be consulted by the Court [in determining whether a circumstance was adequately taken into consideration by the Commission under Section 3553(b)] are *only* the Guidelines, the Commission's policy statements, and its official commentary.") (Emphasis in original.)

Neither does the Sentencing Commission's rejection of addiction as a factor to be considered in sentencing. Sentencing Guideline § 5H1.4 ¶ 2, establish that the Sentencing Commission considered the likelihood of successful treatment for addiction. Section 5H1.4 ¶ 2 states: "Drug dependence or alcohol abuse is not a reason for imposing a sentence below the guidelines. Substance abuse is highly correlated to an increased propensity to commit crime." There is an obvious negative preg-

[1] S. 1762, a proposed Comprehensive Crime Control Act of 1984 passed by the Senate on February 2, 1984, contains the same language under its section 3553(a)(2), as the final version of the Act. 130 Cong.Rec. Part 2 at 1592 (1984).

nant in this statement by the Commission: successful treatment for drug abuse could lead to a reduced propensity to commit crime and thereby reduce the need for the longer periods of incarceration contemplated by the Guidelines with respect to drug law violations. The Sentencing Commission's rejection of addiction as a sentencing factor is no indication of its consideration of susceptibility to successful treatment for drug addiction. rather. the negative pregnant tends to confirm the opposite reading of the Guidelines and the official comments.

Other courts have made similar findings that a successful effort to overcome an addiction is a mitigating factor not considered by the Sentencing Commission. In *United States v. Maddalena*, 893 F.2d 815, 817 (6th Cir.1989), the court reversed a district court determination that it did not have authority to depart from the Guidelines due to the mitigating circumstance of defendant's attempts to free himself from drug use, stating: "we remand this case to the District Court, instructing the judge that he may, but need not consider the defendant's efforts to stay away from drugs as a basis for departing from the guidelines." *Id.* at 818. The court in *United States v. Rodriguez*, 724 F.Supp. 1118, 1119 (S.D.N.Y.1989) (Leval, J.), departed downwards from the guidelines range because the defendant "accomplished an impressive rehabilitation," noting that "[t]he rehabilitation of a drug addict by his act of will is no mean accomplishment."[8]

Courts have also stated that sentencing courts have substantial discretion in deciding to depart based on mitigating circumstances not considered in the Guidelines under 18 U.S.C. 3553(b) and Guideline 5K2.0. *See United States v. Roberson*, 872 F.2d 597, 603 (5th Cir.1989), *cert. denied*, — U.S. —, 110 S.Ct. 178, 107 L.Ed.2d 131 (1989) ("The court's discretion to depart from the Guidelines is broad."); *United States v. Correa-Vargas*, 860 F.2d 35, 37 (2d Cir.1988) (Section 5K2.0 "gives a district court wide discretion in determining which circumstances to take into account in departing from the Guidelines."); *United States v. Sturgis*, 869 F.2d 34, 37 (2d Cir. 1989) ("In *Correa-Vargas* we emphasized the 'wide discretion' accorded district court judges . . . .").

[3] Furthermore, this Circuit has recently upheld an upward departure from the Guidelines on three separate grounds not considered by the Sentencing Commission. *United States v. Burns*, 893 F.2d 1343 (D.C.Cir.1990) *cert. granted*, — U.S. —, 110 S.Ct. 3270, 111 L.Ed.2d 780 (June 26, 1990). The court held on appeal that the Commission did not consider disruption of a government function, duration of the crime, or commission of one offense to conceal the commission of another offense and that each of these factors warranted departure under 18 U.S.C. § 3553(b). The principle authorizing departure in *Burns* applies with equal force in the circumstances here. Thus, the Guidelines and the official comment, including the Commission's rejection of addiction as a factor in sentencing, provide no evidence of consideration of a first offender drug addict's probable success in drug treatment as a factor in sentencing and the absence of consideration of this mitigating factor constitutes a basis for departure where expert opinion and other evidence leads to a finding that successful treatment for drug addiction is likely.

III.

[4] The question remains therefore whether, since departure is permitted because of the likelihood of successful treatment, there should be a departure in this particular case. The preponderance of the evidence including the uncontroverted ex-

8. *See also United States v. Concepcion*, 721 F.Supp. 493, 497-98 (S.D.N.Y.1989) (downward departure under Section 3553(b) warranted in part due to defendant's post-incarceration efforts to reenter society); *United States v. Kopp*, 1 Fed.Sent.R. 123, (D.N.D. Apr. 29, 1988) (downward departure granted for youthful first offender); *United States v. Haigler*, 1 Fed.Sent.R. 34, 37 (D.Minn. May 19, 1988) (special circumstances warranting downward departure from 97 to 84 months include substantial family ties and potential for drug free future with productive employment).

pert opinion establishes that successful treatment of Harrington's addiction is likely and that future criminal activity by him is unlikely. Kelvin Harrington had been using drugs since he was 17 years old and was an addict when he became involved for the first time in the criminal justice system. In the opinion of Dr. Chambers, "If he can continue his current intense commitment to the treatment throughout his incarceration, and possible parole, the long term prognosis is quite favorable. Most men who do accept this way of life do succeed." Letter of Dr. Joseph F. Chambers to Christopher W. Hall (April 24, 1990) at 2. Harrington's ability to meet the conditions in Dr. Chambers' opinion is evidenced by his successful participation in Operation Progress which was described as "excellent." He was also described as "able to focus" and "to display a level of maturity." Letter from Clinton Boyd (February 9, 1990). He secured and maintained employment while enrolled in Operation Progress. A letter from J. Britt, Senior Correctional Officer at Lorton dated December 14, 1989, states: "I believe Resident Harrington['s] diligence and dedication has enabled him to be viewed as a positive role model to other residents in his housing unit." A letter from Jerome Jordan, Substance Abuse Counselor in the Unfoldment Program in which Harrington is currently enrolled, dated May 24, 1990, states that "Mr. Harrington has shown remarkable growth and continues to build his self-esteem." Dr. Chambers described Harrington as "open," "honest," and "willing." At the sentencing hearing on June 27, Harrington's appointed counsel stated that the directors of the Unfoldment Program had offered Harrington the opportunity to participate in a second 48 week program where he could train as a counselor and Harrington expressed an interest in becoming a counselor in the program during a second session. June Tr. at 7.

The White Paper tangentially confirmed the promise of such a program for an inmate like Harrington, finding that therapeutic communities having characteristics similar to those attributed by Dr. Chambers to Lorton's Unfoldment Program, have a:

> good record of success, with as many as 4 out of 5 patients who complete the program drug free several years out of treatment.

Id. at 15. At the sentencing hearing on June 27, 1990, defense counsel reported that Harrington had recently received a certificate for completing the first three months of the Unfoldment program, that only 49 of 60 participants did complete the first three months, and that "[t]hose are the hardest three months of the program." June Tr. at 4. The evidence of Harrington's successful participation in two programs to date and his future commitment to drug treatment is not traversed by any government expert or other information on the record. The entire record, together with the written and oral reports of the Probation Officer to the Court and its observations of Harrington on his several court appearances before and during the jury trial and during the sentencing proceedings further reinforce the expert's conclusion and the strong indicators that Harrington is likely to meet the conditions attached to that conclusion.

Drug addiction and drug trafficking are national calamities. A jury has found Harrington guilty of serious drug offenses. At the same time he is an addict who has demonstrated that he is amenable to successful drug treatment in prison which is likely to cure any criminal propensities. The Sentencing Reform Act of 1984[1] requires that he be punished by a substantial

[1] (a) The court, in determining the particular sentence to be imposed, shall consider—

(2) the need for the sentence imposed—

(A) to provide just punishment for the offense;

(B) to afford adequate deterrence to criminal conduct;

(C) to protect the public from further crimes of the defendant; and

(D) to provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner.

18 U.S.C. § 3553(a)(2).

sentence which will incapacitate him and deter others susceptible to deterrence. The Act also, however, requires that the sentence provide correction by encouraging Harrington's so far successful and promising effort to curb his addiction and materially diminish any propensity for crime.

> The White Paper found that:
>
> Research indicates that those who spend more than three months in a [therapeutic community]—even without completing the program—reduce drug use and criminal behavior.

Id. at 15. As Judge Leval put it:

> [The Sentencing Reform Act] unquestionably envisions more severe sentences for defendants considered more likely to commit further crimes and less severe sentences for those unlikely to commit crimes.

Rodriguez, 724 F.Supp. at 1120. These considerations apply to Harrington.

Accordingly, on June 27, 1990, the Court imposed a substantial sentence of five years incarceration plus four years supervised release, with a request to the government that it continue Harrington's access to the in-prison drug treatment program which Dr. Chambers found to be so promising.

Vikki L. RAVINSKAS, Plaintiff,

v.

S. Steven KARALEKAS, et al., Defendants.

Civ. A. No. 89-3327 SSH.

United States District Court, District of Columbia.

July 16, 1990.

Discharged female employee sued her former employer under the District of Columbia Human Rights Act, alleging sexual discrimination and sexual harassment. Defendant moved to dismiss. The District Court, Stanley S. Harris, J., held that: (1) the action was not time barred; (2) employee alleged sufficient facts to support her retaliation claim; and (3) the definition of "person" in the Act was broad enough to encompass a sole proprietorship.

Motion denied.

1. Limitation of Actions ⇐58(1)

Claims under District of Columbia Human Rights Act were not barred by one-year time limit provided by Act, even though initial occurrence of alleged discrimination occurred more than one year prior to filing of action; alleged sex discrimination and retaliation were ongoing behavior, and last incident occurred well within one-year limitation period. D.C. Code 1981, §§ 1-2512, 1-2525, 1-2544.

2. Limitation of Actions ⇐31

Claim for intentional infliction of mental distress was dependent upon and not entwined with claims under District of Columbia Human Rights Act; thus, mental distress claim was also governed by one-year statute of limitations provided by Act. D.C.Code 1981, § 1-2544.

3. Civil Rights ⇐452

Discharged employee alleged sufficient facts to support retaliation claim under District of Columbia Human Rights Act; employee alleged not only harassment and discrimination but also constructive termination as result of her refusal to consent to further sexual relations. D.C.Code 1981, § 1-2525.

4. Civil Rights ⇐481

Sole proprietorship could be sued for violating District of Columbia Human Rights Act; definition of "person" in Act was broad enough to encompass sole proprietorship. D.C.Code 1981, § 1-2502.

See publication Words and Phrases for other judicial constructions and definitions.

SUPERIOR COURT OF THE DISTRICT OF COLUMBIA

CRIMINAL DIVISION

UNITED STATES	*	
	*	
v.	*	Criminal No. F 5094-89
	*	
EZZARD LAWRENCE	*	
Defendant	*	

O R D E R

After considering defendant's motion for reduction of sentence and the January 16, 1991 letter appended to his supplemental memorandum, the Court finds and concludes that:

1. Defendant's motion was timely filed on April 3, 1990, less than 120 days after sentence was imposed on December 5, 1989. Super. Ct. Crim. R. 35 (b).

2. On December 5, 1989 defendant, who was 38 years old and who had a 20 year record for theft and drug violations, was sentenced to a term of 3 to 15 years for attempted distribution of heroin.

3. On or about February 1, 1991 defendant will complete the first 11 month phase of the UNFOLDMENT drug program. He has been a participant in that phase of the program while serving his 3 to 15 year sentence at the Lorton prison facility. The next phase of the program is a community based aftercare.

4. Defendant's participation in the drug program has been "above average" and he is recommended as a "viable candidate

for sentence reduction" to permit further participation in the UNFOLDMENT program.

5. Reduction of the minimum portions of defendant's sentence would not unduly deprecate the seriousness of the offense or unduly endanger the community.

a. Even if defendant is released to participate in community aftercare, he will be subject to supervision for 15 years.

b. The drug program should deal with defendant's addiction to heroin which appears to have been the primary factor in defendant's 20 year criminal career as a thief and a violator of drug laws.

c. Defendant was the runner/advertiser in a heroin transaction with an undercover police officer. He was not a major trafficker.

Therefore it is this 11th day of February 1991

ORDERED that defendant's motion is granted in part, and it is

FURTHER ORDERED that defendant's minimum sentence is reduced to 18 months, and it is

FURTHER ORDERED that the Clerk of the Court shall file and distribute an amended Judgment and Commitment order.

SYLVIA BACON
ASSOCIATE JUDGE
D.C. SUPERIOR COURT

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Mr. Ezzard C. Lawrence
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D.C. Department of Corrections

Statement of J. Michael Quinlan
Director, Federal Bureau of Prisons

Before The House Select Committee On
Narcotics Abuse and Control

May 14, 1991

Mr. Chairman and members of the Committee, I appreciate the opportunity to appear before you and discuss the extent and severity of the drug and alcohol abuse histories of inmates incarcerated in the Federal Bureau of Prisons. I am pleased to discuss current and planned substance abuse program initiatives within the agency.

The Bureau of Prisons has traditionally believed that the provision of program opportunities for offenders is essential to our mission. We have a proud legacy of providing a continuum of drug treatment programs and services that offenders can use to better themselves, both while confined, and as they re-enter the community. Because the Bureau of Prisons has direct responsibility for both the custody and treatment of inmates, we have taken this opportunity to coordinate supervision with treatment programming in an effort to bring about positive behavioral change in the offender.

Like many state correctional systems, the Federal Bureau of Prisons has experienced a rapid and dramatic increase in inmate population. As of April 18, 1991, there were 61,691 individuals incarcerated in 67 Federal facilities throughout the country. Approximately 55 percent of all Federal offenders are serving time for drug offenses. Projections estimate that the total offender population will exceed 98,000 by 1995, and approximately 69 percent will be incarcerated for drug offenses--more than the total Bureau population today.

It is important to distinguish offenders with substance abuse problems from those who are serving time for drug offenses. Some of the latter group were not substance abusers prior to incarceration, but were simply entrepreneurs who were on the streets making a profit from trading in drugs. On the other hand, inmates incarcerated for non-drug offenses may have a significant substance abuse history that contributed to the inmate's instant offense. The Bureau's treatment strategy begins with appropriate assessment and classification, to distinguish between these two categories of offenders.

CURRENT BOP STRATEGY INITIATIVES

The Bureau's comprehensive substance abuse treatment strategy calls for the development of a continuum of treatment services. This continuum involves interventions of progressive intensities and durations of education and counseling, in order to bring about positive behavioral change in offenders with a history of substance abuse. The Bureau's continuum of substance abuse program services includes:

1) Drug Education Programs
2) Drug Abuse Counseling Services
3) Comprehensive Drug Abuse Programs
4) Pilot Drug Abuse Programs
5) Transitional Services

Drug Education Program

Drug Education is the first level on the Bureau's intervention continuum. While education alone may not meet the treatment needs of all offenders with substance abuse problems, we believe, based on our research and experience, that education provides the foundation upon which successful treatment interventions are constructed. For this reason, the Drug Education Program is required of all inmates with a substance abuse history. In addition, all inmates who want to enroll will be admitted.

The primary objectives of the Drug Education Program are 1) to promote an understanding as to how and why individuals abuse substances or become addicted; 2) to facilitate an understanding of the effects that continued abuse can have on one's health and life; 3) to facilitate an understanding of the difficulties in the treatment of abuse; 4) to demonstrate that treatment can be successful; 5) to convey the understanding that programs are available while incarcerated and in the community; and 6) to develop a sense of trust and cohesion in small group settings, that will increase the motivation of those who are in need of additional intervention and further treatment services.

Inmates who complete the Drug Education Program have an opportunity to earn preferred work assignments and greater opportunities for other privileges.

Drug Abuse Counseling Services

The next level on the continuum is Drug Abuse Counseling Services. These services are available to all inmates at any time during their incarceration. Like community programs, the Bureau's counseling services include both individual and group treatment provided by psychologists and substance abuse specialists. Additional counseling options, in conjunction with community volunteers, include self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), stress management, personal development training, and pre-release planning.

The Drug Abuse Counseling Program is intended to provide maximum flexibility to the needs of the substance abusing offender at each level of impairment. Relatively minor or low levels of substance abuse do not require the intensive levels of treatment needed by individuals with moderate to severe addictive behavioral problems.

Comprehensive Drug Abuse Treatment Programs

The third level on the continuum consists of residential unit-based programs. As in the community, those individuals with moderate and severe substance abuse problems may often require specialized residential treatment programming over an extended time period in order to overcome their dependency on drugs.

Inmates identified as being in need of the residential programming, are referred to an institution psychologist for an assessment of the extent of their substance abuse problems. Inmates with a confirmed moderate to severe substance abuse problem will be considered eligible for program assignment.

Comprehensive Treatment Units include the following features:

1) Programs are located in the inmates' housing unit.
2) Treatment staff-to-inmate ratio of 1:24
3) Program length of 9 months and 500 hours
4) Individualized treatment plans based on comprehensive assessment
5) A prerequisite of 40 hours of Drug Education
6) Between 3 and 4 hours of substance abuse treatment programming per day
7) 280 hours of core group/individual treatment
8) 100 hours of wellness lifestyle training
9) 40 hours of transitional living issues
10) Full unit team reviews every 90 days to assess overall institutional adjustment
11) Treatment team reviews every 30 days, to assess inmate's program progress
12) Substantial frequency of random urinalysis surveillance
13) Institutional work and educational assignments daily

The group and individual treatment issues focus on a variety of skill development issues, both cognitive and behavioral in nature. Criminal thinking confrontation and pro-social values development is included whenever indicated. Family issues, vocational/educational issues, relapse prevention, self-help, personal development and support groups are a routine part of the individual's program.

Treatment includes a strong relapse prevention emphasis. The goal of relapse prevention treatment is to provide individuals with the behavioral and cognitive skills necessary to cope effectively with high-risk situations. Individuals are taught how to achieve a positive lifestyle characterized by a balance between work, recreation, and healthy habits.

Comprehensive Drug Abuse Treatment Programs are being developed in a number of facilities throughout the country. Currently, five units are operational, and plans call for the development of seven additional units by the end of 1991. More are

planned for 1992, with a goal of having approximately 31 Comprehensive Treatment Units, or analogous programs, fully operational by the end of 1992.

Each unit is capable of handling between 100 and 125 offenders, during a 9 month program, yielding a comprehensive program treatment capability of approximately 3,600 offenders annually when all units are fully operational. Planning for the projected growth in the sub-population of substance abusing offenders beyond 1992 is ongoing at this time.

Pilot Drug Abuse Treatment Programs

These programs represent state-of-the-art efforts in intensive residential treatment. Three Pilot Drug Abuse Treatment Programs are operational at Federal Correctional Institutions located in Butner, North Carolina; Tallahassee, Florida; and Lexington, Kentucky. The programs at Butner and Tallahassee serve male offenders, while the facility at Lexington serves female offenders.

The Pilot Programs are similar to the comprehensive programs, but provide intensified treatment strategies including:

1) Treatment staff-to-inmate ratios of 1:12,, as opposed to 1:24
2) Program length of 12 months, as compared to 9 months
3) 1,000 hours of treatment, versus 500 hours

These Pilot Programs also contain a strong research emphasis, and will involve larger investments of staff and fiscal resources. They will remain Pilot Programs until the results of the ongoing program evaluation indicates whether their additional resources produce significantly better post-release outcomes than the comprehensive programs.

Transitional Services

The end point on the continuum involves the reintegration of the offenders into the community. Program coordinators recognize that the success of institutional drug treatment programs is, to a great extent, dependent upon the availability of high quality transitional care programs in the community. Community programs that deal constructively with the problems faced by the offender upon release are an integral part of our program.

After successful completion of the institutional treatment program, the offender prepares for community re-entry through Community Corrections Centers. This preparation occurs during the last few months of treatment, particularly in the relapse prevention area. High risk situations and a specific relapse prevention plan is prepared for the individual. Family issues, job issues, supervision concerns are discussed in detail. Individuals will be gradually phased into the community over a period of up to six months, depending upon a variety of factors related to the

offender's criminal history, assessed risk to the community, institutional adjustment, program performance, and assessed needs.

Several recommendations for service delivery have been adopted for the transitional phase:

1) Individual and group counseling sessions for varying time frames throughout the transitional services period.
2) Treatment focus on family, work adjustment, residential living issues, and relapse prevention planning through written assignments and group discussions.
3) Assistance in identifying and obtaining employment.
4) Random urinalysis occurring with decreasing frequency throughout the program duration.
5) Documentation of all contacts by all service providers who are certified or appropriately licensed.
6) Transitional Care Coordinators in each facility who arrange and monitor service delivery.

Inmates who successfully complete either the comprehensive or pilot program will be given priority for receiving post-release transitional services. They will be located in those areas where inmates from the pilot and comprehensive programs are to be released.

PROGRAM EVALUATION

The development of high quality treatment programs is a foreboding challenge in any setting, particularly within the realm of corrections. Similarly, the development of both process and outcome evaluation strategies for the treatment interventions delineated herein have required extensive planning as well. Not only are such evaluations of interest for the knowledge they yield, but high quality evaluations are also required to assess credibility and accountability of program efforts.

In developing an evaluation plan for the current intervention strategy, the groundwork has been established for one of the most comprehensive, longitudinal evaluations ever conducted with correctional populations regarding the effectiveness of professionally managed drug treatment programs. This is reflected in the Proposal for the Evaluation of the Federal Bureau of Prisons' Drug Abuse Treatment Programs submitted to the National Institute on Drug Abuse (NIDA), in March, 1990. NIDA's 2.74 million dollar contribution to the program evaluation, under an interagency agreement, has provided the mechanism through which important information concerning the effectiveness of institution-based drug treatment programs can be gained in the months and years ahead.

This concludes my prepared statement, Mr. Chairman. I would be pleased to answer any questions that you or the other members of the committee may have concerning this important area.

STATEMENT OF

BENY J. PRIMM, M.D.

ASSOCIATE ADMINISTRATOR FOR TREATMENT IMPROVEMENT

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

MAY 14, 1991

RELEASE ONLY UPON DELIVERY

Mr. Chairman, members of the Select Committee, I am Dr. Beny Primm, Associate Administrator for Treatment Improvement in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The Office for Treatment Improvement (OTI) has been charged with providing leadership for our national effort to improve substance abuse treatment. To accomplish this goal, OTI works with the research Institutes within ADAMHA and with other Federal agencies to identify effective treatment methodologies. Additionally, OTI provides financial and technical assistance to States in order to facilitate the transfer of efficacious treatment technologies.

It is a pleasure to appear before you today to discuss ADAMHA's efforts to improve substance abuse treatment within the criminal justice system. Addiction treatment in this arena is a critical component of the Nation's war on drugs. The Office of National Drug Control Policy (ONDCP) indicates that 30 percent of the treatment population is referred from the Criminal Justice System. It is fitting that we, as a Nation, target our efforts on the criminally involved addict for three reasons: the need is great, substance abuse treatment works, and there is growing willingness for collaboration between the addiction treatment and criminal justice fields in order to make a difference. It is also important to note that the President's National Drug Control Strategy strongly emphasizes drug treatment and the criminal justice system.

The Need for Improvement of Substance Abuse Treatment in the Criminal Justice System

A large segment of jail and prison populations in the U.S. are drug users or abusers. Persons using drugs are likely to have considerably more prior and subsequent arrests than non-using arrestees. Only a fraction of this population ever receives treatment for their addictive disorders, and the size of this population is large indeed. Bureau of Justice Assistance (BJA) statistics indicate that there are currently 800,000 inmates in Federal and State prisons. 9.7 million persons are admitted to the Nation's 3,500 jails each year, and 9.6 million persons are discharged from jail to the community. Eighty percent of these incarcerated individuals have a history of drug abuse.

The chronicity of drug use and criminal behavior is startling. Up to two-thirds of inmates in some States (e.g. Oregon and Texas) are past probationers and parolees, the majority of whom are involved with drugs. U.S. Bureau of Prison data show that 79 percent of the total increase among those sentenced to prison over a recent two year period was due to drug offenses (GAO Report, October, 1989).

The increasing rate of cocaine and crack usage and addiction and its effects on drug-related criminal behavior, is also well-documented. According to the National Council on Crime and Delinquency, the heavy law enforcement emphasis on crack has

caused incarceration rates to rise rapidly, especially among Blacks and Hispanics (1989 Prison Population Forecast, December, 1989).

The research of Dr. Eric Wish, University of Maryland, indicates that much of the demand for cocaine in the United States stems from persons detained and supervised by criminal justice agencies. He concludes that the same degree of attention and resources that have been directed towards casual drug users must now be directed toward the criminal justice user.

In spite of the demonstrated need for treatment services among the criminal justice population, many inmates, probationers and parolees are still in need of treatment for their addictive disorders, either before or during their incarceration.

Treatment Works

The second factor I mentioned in my opening is that "treatment works." There are some "success stories" indicating that substance abuse treatment can be effective. Moreover, there are characteristics endemic to the criminal justice system that are conducive to the delivery of cost-effective, successful substance abuse treatment.

4

Efforts to establish substance abuse treatment as an integral component of corrections within the criminal justice system have been limited but promising. One of the most prominent examples is Treatment Alternatives to Street Crime (TASC). TASC provides case management for defendants or offenders who suffer from addiction. TASC acts as a bridge between criminal justice agencies (courts and probation) and treatment providers. TASC usually provides screening and assessment, treatment planning, monitoring, and urinalysis, together with court liaison activities. There are currently 173 TASC projects located throughout the country.

The concept for TASC was developed as a result of research which indicates that treatment is more effective in a setting where legal sanctions and close supervision provide incentives for patients to conform with treatment program protocols and objectives. Statistics show that offenders with TASC supervision remain in treatment longer. TASC clients, under legal coercion, tend to remain in treatment six to seven weeks longer than other criminal justice referred clients. This holds for clients who have been referred to both residential and outpatient treatment programs. Longer treatment duration is associated with better treatment outcomes. Additional examples of model programs include:

- New York's "Stay 'n Out" treatment program at Arthur Kill prison, which involved a 9 to 12 month comprehensive substance abuse treatment and aftercare program, produced a success rate of 78 percent (measured in terms of the percentage of parolees who completed parole without re-arrest). Comparison groups involving no treatment or just basic counseling showed less than a 50 percent success rate. The "gains" experienced by parolees who received comprehensive treatment services persisted, as illustrated by results of three and nine year follow-up evaluations.

- Similar jail treatment projects have now been initiated in Tucson, Tampa, Chicago, Seattle, and most recently Montgomery County, Maryland. The Tucson Sheriff/Amity Jail Project involves the adaptation of the Therapeutic Community (TC) model (the model involves intensive group interaction and behavior modification in an isolated and supportive treatment unit) to a jail environment. Chicago/Cook County has turned traditional large dorm units into TCs. Initial outcome research is promising. Five other jails have initiated treatment programs replicating one of the model jails, and eleven more have formal plans to begin projects this year (follow-up of training developed by the American Jail Association).

- The New York legislature recently adopted a coordinated approach to interdiction and treatment in its "Omnibus Prison Bill," a $1 billion package that emphasizes a treatment approach, and makes an Alcohol and Substance Abuse Treatment Facility (750 beds) and seven 200-bed Substance Abuse Annexes, the core of its expansion efforts. Amending existing executive, penal, and appropriations laws, the New York legislation is the first comprehensive legislation of its kind. Included in the package are requirements for County assessments and plans to develop alternative punishments and services for addicted persons. Though budget limitations are restricting this initiative, the State is moving ahead with the seven, 200-bed Annexes.

These examples lay the groundwork for future success. However, I would like to stress the need for additional research, program development and evaluation in this sphere. For instance, we do not know at this juncture, "what works" for different criminal justice population sub-groups. We do not know which treatment/incarceration models are the most effective in terms of treatment outcome. Moreover, a great deal of work needs to be done toward developing tighter case coordination between the criminal justice system, the States, and the treatment provider community. In short Mr. Chairman, we need to know more from the corrections and treatment arena.

Collaborative Activities

The third and final point I made in the opening of this statement concerned the emerging commitment and mobilization of the substance abuse and criminal justice fields to address this issue. This commitment and mobilization was demonstrated by the representation of addiction treatment and corrections officials from all 50 States at OTI's recent conference "Creating Linkages to Improve Substance Abuse Treatment for Criminal Justice Populations". ADAMHA is engaging in collaborative efforts with the American Correctional Association, the Department of Justice, the National Judicial College, the American Correctional Association and the American Jail Association. And certainly, Mr. Chairman, the Office of National Drug Control Policy and the Administration overall has demonstrated its overall commitment to treatment in the criminal justice system by requesting $185 Million for this purpose in the FY 1992 President's budget. This is a 34% increase since FY 1990.

Based upon my thirty-plus years of experience as a treatment practitioner specializing in urban, "underserved" populations, it is my opinion, and the opinion of many in the treatment field, that a person's addictive disorders cannot be addressed in isolation from his or her medical, psychological, social, and practical deficits (e.g. lack of housing, inadequate communications skills, inadequate job skills). Habilitation programs, including comprehensive programs of drug/alcohol

treatment have been shown to have a considerable impact on recidivism among these populations, provided the duration of treatment is sufficient. A well coordinated continuum of therapeutic and habilitative care is therefore warranted for criminal justice populations. Such a continuum of services must include HIV testing, counseling and treatment. A recent study reported in the Journal of the American Medical Association indicated that inmates are far more likely to be HIV seropositive, especially racial and ethnic minority populations and women.

It is particularly important that comprehensive treatment services provided outside of confinement are delivered in a "one-stop shopping" approach, where all services are either provided at a single site, or through case management. To promote these objectives, OTI has developed the "Comprehensive Systems Approach". Further information is available on request.

We know that drug addiction is a chronic relapsing disorder that often requires support services, of one form or another, over one's life-time. Therefore, on-going treatment and consistent follow-up are a hallmark component of successful treatment, whether it occurs inside or outside of the criminal justice system. In addition, there is a beneficial aspect of "coercion" from a therapeutic perspective: The criminal justice system (e.g. police, jails, pretrial services, courts, and State

corrections agencies) has inherent factors that are conducive to successful treatment and can provide a unique opportunity to identify, track and manage this population. Hence, we need to explore the advantages of linking treatment efforts with existing community-based programs to more efficiently perform requisite case tracking and follow-up functions.

Therefore, ADAMHA supports a coordinated systems approach to providing comprehensive substance abuse treatment for all individuals in the criminal justice system who need such treatment. Further, the criminal justice system is a grouping of many decision points through which treatment services could be provided to addicted offenders. Intervention with treatment services is possible -- and recommended -- at each of those points: arrest, pre-trial, pre-sentencing, trial/sentencing, corrections and parole. In light of this, ADAMHA cautions against focusing solely on prisons in legislation designed to enhance treatment in the criminal justice system.

There is intense interest in initiating or expanding treatment in all criminal justice settings throughout the country. Corrections administrators, legislators, governor's offices, and others are increasingly aware of the need to insure that intensive drug and alcohol treatment programs, coupled with other habilitation programs, are utilized in conjunction with interdiction efforts.

Along these lines, OTI is fostering the provision of treatment and habilitation services at correctional facilities. An example includes an OTI program which supports the Ventress Correctional Facility in Alabama, a 600-bed medium security institution which has been devoted to drug treatment services.

Additionally, the provision of substance abuse treatment services as an alternative or adjunct to incarceration can help to alleviate part of the criminal justice burden. This can be accomplished in two ways:

1) For those persons who qualify, diversion-to-treatment as an alternative to prison or jail or early-release-to-treatment following incarceration, may be acceptable and preferable alternatives, thus alleviating part of the local jail and prison burden. It is very important to note however, that diversion-to-treatment and early-release-to-treatment programs require two elements which may or may not be available in any given community: 1) TASC or a TASC-like mechanism to ensure coordinated case management of persons in the system, and 2) enough treatment capacity within the community to satisfy the demands of the local criminal justice system. However, it should also be noted that nonincarceration alternatives do not relieve a prisoner from denial of liberty or the sanctions of the criminal justice system.

2) For persons for whom diversion or early release would not be appropriate for a variety of reasons including the protection of society, the criminal justice system already bears the financial burden for security, room, board, and other inmate services. Treatment can be provided as an ancillary service that should be less costly than in other public and private sector settings.

Instituting treatment programs as adjuncts to civil or criminal sanctions is enabling us to reap some rewards for the corrections and treatment dollars spent, while at the same time, reducing the demand for drugs and improving the public welfare. The potential for both decreased drug use and reduced drug-related crime is significant if we can provide enough effective treatment that is of sufficient duration to change behavior. For these reasons, treatment within the criminal justice system has the potential to be one of the strongest, and most cost-effective components, of our Nation's demand reduction strategy. At the same time, Mr. Chairman, I must caution you that treatment will not work for everyone in the criminal justice system.

In planning services for provision in criminal justice settings, the unique substance abuse treatment needs of female addicts should be considered. These needs include: 1) individual treatment needs; 2) immediate medical needs to protect maternal and infant health; and 3) long range needs in developing bonding and parenting skills to provide for the physical and psychological well being of her children. To address these needs, OTI's Division for State Assistance is developing treatment protocols for: 1) the clinical methods for treating substance abuse by pregnant addicts; and 2) programmatic guidelines to ensure long range solutions and considerations for the mother and her infants.

Existing Programs and the Potential for Future Success in Our Efforts to Improve Treatment Within the Criminal Justice System

As I noted at the start of my testimony Mr. Chairman, OTI works closely with National Institute of Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism, the National Institute of Mental Health, and the Office for Substance Abuse Prevention (OSAP) within ADAMHA to improve the quality of substance abuse treatment nationally. OTI, NIDA, and OSAP, in conjunction with the Department of Justice, have implemented initiatives specifically geared toward treatment improvement in criminal justice settings.

In OTI, we have initiated several programs designed to improve treatment systems for criminal justice populations. In FY 1990, OTI allocated $8 million of its discretionary funds to initiate demonstration projects for treatment improvements within the criminal justice system. Under the auspices of this program, the following grants have been made to States:

Correctional Settings Program

Six prison-based and 3 jail-based treatment improvement programs have been funded for three years, beginning in FY 1990. Of these nine programs, one is in a State prison for women and another is a secured facility for juvenile offenders. With OTI grant enhancements, service delivery units will be enhancing services through such mechanisms as adding staff and the capability to provide increased service to racial and ethnic minority populations. With the grant enhancement, all nine programs are able to offer case management and seven will offer aftercare services.

Non-Incarcerated Offender Programs

These 10, three-year treatment improvement demonstration projects are located in nine States and Washington, D.C. Five projects offer services to adolescents, two exclusively. Two programs serve one-third or more females, including pregnant females. OTI has consulted extensively with the Bureau of Justice Assistance in the development and implementation of this program.

In FY 1991, OTI has allocated $16 Million to provide for the following programs and awards: 1) continuation of the FY 1990 grant programs described above; 2) funding of eight additional FY 1990 applications that did not receive awards in FY 1990; 3) a new Adolescent/Juvenile Justice treatment improvement grant program, expected to fund 12-15 demonstrations that will focus on developing community treatment networks for adolescents and on treatment in State juvenile institutions; and 4) contractual technical assistance and training.

Technical assistance funds will be utilized to provide support services for all OTI demonstration projects including introductory workshops for interested jurisdictions which do not currently provide substance abuse treatment services for their criminal justice populations. OTI is working in concert with the BJA to develop these programs.

OTI is focusing upon treatment, coordination and linkages within the criminal justice system, in every sphere of OTI programmatic activities. Coordination between criminal justice efforts and substance abuse treatment is a requirement for OTI's Target Cities Program, a demonstration program that consists of three-year cooperative agreements with 8 States to effect a coordinated service delivery milieu in metropolitan settings.

These demonstrations are a key component of OTI's technology transfer efforts. OTI hopes to utilize these demonstrations and the National Treatment Improvement Evaluation Study, which will evaluate the impact of these projects on both treated individuals and the community as a whole, to illustrate "what works" and then assist States with the implementation of proven, efficacious treatment technologies.

ADMS Block Grants/State Plans

As part of our efforts to manage the Alcohol, Drug Abuse and Mental Health Services [ADMS] Block Grants, we are assisting States with the development of comprehensive Statewide Substance Abuse Prevention and Treatment Action Plans [hereafter referred to as State Plans]. It is our intent that States will build treatment improvement efforts within the criminal justice system into their comprehensive planning and implementation processes.

Though comprehensive State Plans are not, at this juncture, a Federal requirement, OTI has been working with the National Association of State Alcohol and Drug Abuse Directors (NASADAD) to institute a voluntary state planning effort. I firmly believe that this type of Federal/State partnership is both necessary and inevitable if we are to continue making progress in eliminating drugs as a major source of crime and community disintegration.

NIDA Initiatives

OTI's efforts to enhance the quality of substance abuse treatment within the criminal justice system are only the latest in a series of ADAMHA initiatives in this area. NIDA has long been involved with efforts to improve treatment within the criminal justice system. NIDA also serves as advisor to the American Probation and Parole Association, the National Criminal Justice Association, and the Drug Use Forecasting Advisory Board.

NIDA has collaborated with the National Institute of Justice (NIJ) in establishing a research demonstration program to assess the effectiveness of short-term educational interventions concerning AIDS/HIV infection, transmission, and prevention, and drug abuse treatment referral directed at arrestees held in booking and/or lock-up facilities. Under this research demonstration program, an intense treatment referral and counseling intervention is being compared with a more typical AIDS information approach in at least three lock-up/booking facilities.

The Treatment Research Branch within NIDA is sponsoring several studies and projects which impact the criminal justice system:

- An evaluation of the KEEP-ITS program, funded in 1989, which recruits and treats drug abusers in New York City jails and

provides drug abuse treatment and AIDS education during and after incarceration.

- In collaboration with the State of Delaware on a research demonstration project called Assertive Community Treatment Program for High-Risk Drug Users, which compares the relative effectiveness of three models of drug abuse treatment and AIDS prevention/intervention within a population of parolees that is at high risk for HIV infection.

- NIDA is in the process of evaluating a program of treatment, social skill-building, and aftercare for juvenile justice-referred clients in Seattle, WA.

- NIDA and the Federal Bureau of Prisons (BOP) are conducting a multi-year evaluation of intensive drug treatment demonstrations being conducted by the BOP. Also, in response to the rising number of drug-abusing offenders within the BOP, NIDA will assist in establishing and evaluating a 12-month vs. a 9-month residential treatment program.

- A research demonstration project aimed at evaluating the effectiveness of a Therapeutic Community Work Release Center for Inmates who are going from prison to a work release

center prior to release from custody.

- A grant to evaluate the Stay'N Out program, a prison-based therapeutic community study which compares Therapeutic Communities inmates with inmates who did not receive this kind of treatment to determine what difference, if any, there may be in reducing recidivism after release from prison.

- And in 1992, NIDA will develop a drug abuse research initiative in State prisons which will evaluate on a longitudinal basis the effectiveness of prison-based treatment, and certain critical components of that treatment, in reducing drug use and criminal activity upon the individual's return to the community.

All of NIDA's research efforts in this arena are devoted to developing more effective interventions for criminal justice populations. However, there are still numerous gaps in our understanding of efficacious treatment for this population. Once again, additional research studies from both criminal justice and substance abuse experts are required in order to develop substance abuse treatment technology in this area.

OSAP High Risk Youth Program

OSAP is now concluding a cross-site evaluation of the 130 High-Risk Youth demonstration projects funded in 1987. Four of these projects are: 1) Inroads to Intervention in Colorado; 2) Kamalama Youth Program in Hawaii; 3) City Lights in the District of Columbia, and; 4) Drug Abuse Reduction Training (DART) in Vermont. Many of these programs involve comprehensive treatment and prevention programs for youths who are court-involved, declared truants by the court or educational system, or are at-risk of becoming involved in the criminal justice system. Early indicators show that youths who are involved with these programs tend to stay in treatment longer, a finding which is closely associated with successful treatment outcome.

State/Local Initiatives

State and local efforts to implement treatment improvement initiatives in the criminal justice system continue. Some State corrections agencies are developing specialized substance abuse treatment units in current institutions, setting aside a wing or a floor of a current institution for treatment purposes. Many community-based treatment programs are developing collaborative treatment strategies with local departments of corrections, both in the adult and juvenile justice arenas. OTI, OSAP, and NIDA will continue to support these initiatives through further

research, evaluation and technical assistance grants in 1991 and beyond.

Conclusion

In summary, a significant number of drug abusers in the criminal justice system are capable of being habilitated and the criminal justice infrastructure provides us with fertile ground for efficacious treatment. Thank you for the opportunity to share these insights. This concludes my testimony. I will be glad to answer any questions the Committee may have.

ISBN 0-16-035442-0

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